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STATE OF CALIFORNIA
MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

BUSINESS MEETING
MORNING SESSION

8:30 A.M.

Friday, December 12, 1997
1201 K Street, Chamber of Commerce Building
12th Floor, Conference Room
Sacramento, California

REPORTED BY:
Joanna Austin,
CSR, RPR 10380
Our File No. 40693

1 APPEARANCES:

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3 Dr. Alain Enthoven, Chairman

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5 Alice Singh, Deputy Director for Legislation
and Operations

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7 Hattie Skubik, Deputy Director for Policy and
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18 Maryann O'Sullivan

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19 Anthony Rodgers

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20 Ellen B. Severoni

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21 David J. Tirapelle

Ronald A. Williams

22 Allan S. Zaremborg

Steven R. Zatkin

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24 Ex-Officio's

25 Kim Belshe

Michael Shapiro

26 David Werdegarr

27

28

1 (Roll call.)

2 DR. ENTHOVEN: We do not have a quorum, but
3 the parliamentarian tells me that we may proceed with
4 taking public comment at this time. So we're going to
5 begin by taking public comment which we may do without a
6 quorum.

7 Let me say with respect to the public
8 comment, as everyone knows, we have an exceedingly tight
9 schedule to accomplish today and it's very important that
10 we move very expeditiously through all of these
11 proceedings. Nobody is going to have enough time to speak
12 on all of these things. So particularly with respect to
13 the public, I want to say we've been at this for seven
14 months. We've received numerous presentations in person.
15 We have been flooded with faxes. I just don't think it's
16 possible that some of the major associations could have
17 failed to communicate their views.

18 So I'm going to request that members of the
19 public who speak be particularly concise. I will enforce
20 a three-minute limitation. If there are several members
21 of the public who have the same point of view and know it,
22 I would appreciate it if you would designate one
23 spokesperson and then limit yourselves to getting up and
24 introducing yourself and saying, "I agree with that
25 speaker."

26 I think it's particularly important -- and
27 actually this is true for the task force members also --
28 that we not engage in restatement of things that have

1 already been stated. So I ask everyone's cooperation and
2 helping us to move very quickly. Our time problem was bad
3 enough when we didn't have fog-delayed arrivals. But
4 since we do, we will begin now.

5 Maureen O'Haren from the California
6 Association of Health Plans will talk to us about
7 physician incentives.

8 Ms. O'Haren, please speak out loud.
9 Apparently we got our electronics from the low bidder
10 again. It's just one that doesn't work. I'll tell you,
11 it sure beats rats running around.

12 MS. O'HAREN: Thank you, Mr. Chairman. My
13 understanding is I will get three minutes to talk about
14 this paper and we will still take testimony on other
15 papers as they come up.

16 Is that the case?

17 DR. ENTHOVEN: Yes. Although as time goes
18 by, we may have to shorten it.

19 MS. O'HAREN: I will be brief. I think that
20 our main outstanding concerns with this paper, first of
21 all, there hasn't been --

22 MR. NORTHWAY: We can't hear you.

23 MS. O'HAREN: I'm sorry. We're talking
24 about the physician incentives paper.

25 I think the main outstanding concern that we
26 have or couple concerns is that I think that
27 Recommendation 2 will have to be revisited once the task
28 force decides the ultimate outcome of regulatory

1 organization paper because it would be inappropriate for
2 the agency regulating health care service plans alone to
3 be working with the company medical groups without
4 involving the plans in any sort of program as far as
5 disclosure of incentive arrangements.

6 So I think that either the language of
7 Recommendation 2 has to include health plans in this
8 process or if that agency is regulating medical groups,
9 then it would be appropriate. But not unless that is the
10 case.

11 MR. NORTHWAY: I'm sorry. I'm not sure
12 which specific paper you're talking about.

13 MR. LEE: Provider incentives.

14 MS. SINGH: Or financial incentives.

15 MS. O'HAREN: I thought we agreed it was
16 going to be provider.

17 MR. LEE: Agenda item 6-B.

18 MS. O'HAREN: Yes. Thank you.

19 I think we also have to clarify language
20 regarding Recommendation 4(a), the language that says
21 "receives capitation payment for the substantial costs of
22 professional services including professional services, et
23 cetera" implies that you can't accept any capitation for
24 professional services. So I think that needs to be a
25 little bit reworded.

26 There's also a serious concern with the
27 Recommendation 4(c) in the way it's worded implying that
28 we should be adopting the definition of federal law and,

1 by implication, the regulations and the burdensome
2 reporting requirements associated with that. I talked to
3 an attorney who's sort of an expert on this and he has
4 said that not only will it be burdensome even if you're
5 already in MediCare/Medicaid because the financial
6 incentives to the commercial population may differ
7 requiring providers to redo the calculations, but it has
8 not yet determined what is adequate stop/loss. So really
9 it's going to be very difficult to go ahead and apply this
10 in light of all the confusion that is surrounding it.

11 I think if we could find a simpler way of
12 basically saying that anybody that's at substantial risk
13 or anybody at risk for what they don't provide directly
14 should have some form of stop/loss self-insurance or other
15 sort of financial protection.

16 MR. ZATKIN: Alain, a comment on that last
17 one if I may.

18 DR. ENTHOVEN: Yes.

19 MR. ZATKIN: Maureen, I believe that the
20 reference to federal regulation refers to the definition
21 of substantial financial risk, not anything else.

22 MS. O'HAREN: But how would you calculate
23 that?

24 MR. ZATKIN: 25 percent.

25 DR. SPURLOCK: Or 25,000.

26 MR. ZATKIN: In the case of a physician,
27 it's where at least 25 percent of potential income is at
28 risk. But that doesn't go to the question of the amount

1 of stop/loss you have to have or anything else. That's my
2 reading of it. If that's not correct --

3 MS. O'HAREN: I guess we also have to define
4 -- inevitably at the state level, they will have to define
5 what adequate stop/loss amounts to. But in terms of how
6 to calculate when you have 25 percent -- and that is
7 required under the federal rule that each tier in terms of
8 the plan contracts with IPA, IPA contracts with the group,
9 the group contracts with somebody else. And every level
10 of that relationship has had to go ahead and do
11 calculations to determine if ultimately the plan has put
12 anybody at 25 percent risk. So it is a very complicated,
13 burdensome sort of thing. That's what I'm hearing back
14 from the attorneys who are helping the plan.

15 DR. ENTHOVEN: This is with respect to
16 which, Maureen?

17 MR. NORTHWAY: 4(c).

18 MS. O'HAREN: All I can say is I'm concerned
19 that invoking the federal law is going to create some
20 problems.

21 DR. ENTHOVEN: You mean it's going to create
22 problems if we say we ought to conform to federal law for
23 the rest of the patients?

24 MS. O'HAREN: Yes.

25 DR. ENTHOVEN: One more unintelligible law.

26 MS. O'HAREN: I think some of the plans had
27 offered to just say, "We will admit to being at least 25
28 percent. Can we just make sure the stop/loss is there?"

1 And HCFA has said, "No. You have to do this
2 paperwork and all your providers have to do the paperwork
3 for all the incentive arrangements that they are under."

4 MR. ZATKIN: This is a definition, not a way
5 of determining whether you met it.

6 MS. SINGH: The microphones are working now
7 so would you please utilize them. Thank you very much.

8 MR. NORTHWAY: As we toss around glibly that
9 you should have stop/loss, people should understand that
10 if it's good stop/loss, that is if it does the job, it is
11 very expensive. I'm not saying you shouldn't have it.
12 But when you start mandating that people have stop/loss,
13 if it's going to do the job, it is expensive because
14 insurance companies feel they are going to be paying it,
15 so you're going to be paying a big premium. And that's
16 going to be borne by somebody.

17 DR. ENTHOVEN: When the task force is
18 actually discussing it, can we revisit that with your
19 help? Okay. Thank you, Maureen.

20 Next we're going to have Conni Barker. This
21 is physician/patient relationship. Conni Barker,
22 California Psychiatric Association. This is a comment on
23 the physician/patient relationship paper.

24 MS. BARKER: Thank you, Mr. Chairman. I
25 didn't expect to come up so quickly. I believe the staff
26 has distributed to you a letter from Senator Scher about
27 this particular paper. It's a self-explanatory letter,
28 but I'll highlight a little bit.

1 Senator Scher is carrying Senate Bill 1129,
2 which is very similar to Recommendation No. 2-A-1 in your
3 paper. There are a couple of problems with the
4 recommendation that we recommend changing, however. SB
5 1129 and this recommendation recommend a provision for
6 continuity of care between a physician and patient when a
7 physician is removed from the panel, and it generally
8 applies to pregnancy and severe illnesses in which there's
9 an episode that's under care so that the physician is
10 continuing caring for the patient until the episode is
11 over. Most commonly this will be with psychiatric
12 patients, but there are many other situations that it will
13 apply to.

14 Your paper suggests that the regulatory
15 agency be authorized to require plans and medical groups
16 to provide for this continuity of care. As we read it --
17 and we don't think it's the intent of the task force -- it
18 would provide for the regulatory agency to have full
19 discretion as to whether to do this or not. So we're
20 recommending that the word "authorize" be changed to
21 "direct."

22 Then there is a second provision in B that
23 we think is too complex to address at this time -- it
24 probably should be removed -- and that deals with
25 physician compensation. It's not a problem when the
26 physician was on contract for individual patients. But
27 where you have capitation, you have to rearrange the
28 contract because the physician, instead of having a large

1 group where the risk is spread, will only have the really
2 sick patients. So under the Hippocratic Oath, they well
3 may be taking on, at their own expense, taking care of
4 these patients. So in that case, the compensation has to
5 be adjusted.

6 It gets complex. We've been discussing it
7 with the HMOs for sometime. So we suggest that that
8 simply not be addressed because it's too difficult at this
9 point to do it.

10 DR. ENTHOVEN: Strike the whole
11 recommendation?

12 THE WITNESS: Just the part that says
13 "accept the plan's rate as payment in full" because B also
14 relates to quality assurance and provision of medical
15 records, and that's a good idea. So what we recommend is
16 that in line 1 of A-1-A, the word "authorize" be changed
17 to "direct" and that in B, the words "accept the plan's
18 rate as payment in full" be stricken.

19 DR. ENTHOVEN: Well then, does that mean the
20 plan would have to pay whatever the provider demanded?

21 MS. BARKER: Not necessarily, Mr. Chairman.
22 This language is attached to Senator Scher's letter, the
23 recommended changes. But the problem is, as we discussed
24 with the HMOs and the IPA, they are going to have to
25 adjust the compensation depending on the individual
26 situation.

27 If the doctor was on some kind of limited
28 number of patients, they will probably just continue with

1 the same rate of payment. If there are capitation, they
2 will probably look at the market and determine the nature
3 of the compensation.

4 MS. O'SULLIVAN: I have a question. I
5 appreciate your concern about the capitation as it relates
6 to patients. Are you concerned, though, if we don't say
7 that the existing rate is what the doctor will get that
8 the doctor will be in the position of on her own
9 negotiating with the plans with no protection?

10 MS. BARKER: Or they could be in a position
11 of having no negotiating leverage and ending up giving
12 free care at some kind of very low, low rate care because
13 their oath is such that they are going to continue taking
14 care of the patient until the patient can safely be
15 transitioned.

16 DR. ENTHOVEN: Okay. Thank you very much.

17 Our next presenter is Catherine Dodd on
18 physician/patient relationships. We're still on the same
19 paper.

20 MS. DODD: Good morning. Catherine Dodd,
21 American Nurse's Association of California. And I want to
22 draw your attention specifically to page 2 and page 3 of
23 the findings and recommendations section.

24 MEMBER: Which paper?

25 MS. DODD: Physician/patient relationship
26 paper.

27 MS. SINGH: Member, items 4(d).

28 MS. DODD: No. Item 6(d), page 2 and page

1 3.

2 It was acknowledged at the first meeting
3 where the tax force considered this paper that the intent
4 of the legislature when the Richter Commission was created
5 was to not just apply the word "physician" but to apply it
6 broadly to providers. In fact, this task force has taken
7 action on that. And I want to again say that there are
8 many, many health care providers who share the sacred
9 covenant that Cardinal Bernaden talked about.

10 Specifically on page 2, we would like to
11 suggest that the word "physician" be changed to "health
12 care provider" throughout that paragraph. In addition,
13 the word "primary care physician" should reflect the
14 actual practice, which is primary care practitioner and/or
15 provider. And that terminology is used elsewhere in other
16 papers, so I'm advocating for consistency in the broader
17 definition. Did you all find that we're talking about
18 page 2, section A, "Continuity With Physician"?

19 On page 3, section E, "Physician
20 Availability." While the language is much improved over
21 the discussion version, we object to the implication that
22 managed care organizations only use advanced practice
23 nurses and physician assistants to reduce costs.

24 We suggest the following: "Many managed
25 care organizations use advanced practice nurses and
26 physician assistants to provide preventative, primary, and
27 secondary care and reserve physician time to care for
28 patients with complex disease processes." All patient

1 visits have a medical and emotional impact on patients,
2 not just the ones doctors have with patients.

3 Consumers report that advanced practice
4 nurses and physician assistants often communicate more
5 clearly than physicians because they are not limited by
6 time constraints. So I'm acknowledging that the
7 communication problem is often one of time constraints.

8 So the two issues are being provider neutral
9 throughout page 2, section A, and to not imply that the
10 only reason managed care organizations work with
11 non-physician providers is because we save money. It's
12 also because we provide good care.

13 DR. ENTHOVEN: Thank you.

14 Our next presenter is Maureen O'Haren on
15 consumer involvement.

16 MS. SINGH: Item No. 6(g).

17 MS. O'HAREN: This is consumer involvement.
18 I think our first concern is with the recommendation on
19 the booklet. I think that we're confusing the lack of
20 knowledge about managed care with a lack of information.
21 It's simply not the case. There's plenty of information
22 out there. People just don't have the time in their busy
23 lives to read it. I think we feel this education booklet
24 is probably not a wise expenditure of resources.

25 I think that the recommendation in the
26 standardization of benefits paper is probably clear with
27 regard to this standard product description or standard
28 outline proposal and Recommendation 2. It probably should

1 be worked together in some way. It's not really clear how
2 they differ, but they seem to be the same.

3 Recommendation 3 would require that plans
4 submit some data on how often certain specialty centers do
5 certain procedures when they have sent somebody to that
6 particular thing. And I think that the physician/patient
7 relationship paper has a recommendation that the
8 individual specialty center provide that data directly.
9 And we think that's a more appropriate source that these
10 centers of excellence do their own reporting rather than
11 the plan having to report through some sort of database on
12 who they have used or ten top services. So I would
13 suggest that the physician/patient relationship
14 recommendation in this area be used in instead of this
15 particular one.

16 DR. ENTHOVEN: I think the idea is before
17 people sign up for a health plan, if they wonder where do
18 I or my family members get sent if I have any of these
19 complicated things, they need to know where that health
20 plan refers people.

21 MS. O'HAREN: I think we see a lot of
22 advertising around open enrollment time by the health
23 systems themselves. Sutter, for example, they will
24 advertise their expertise and say which plans they are
25 with. They go to the health fairs and so forth. It would
26 probably be more appropriate for them to be doing this. I
27 think this creates more of a data burden for the plan in
28 addition to everything else in the task force's

1 recommendations.

2 DR. ENTHOVEN: Is every cost a data burden?

3 MS. O'HAREN: I guess it depends upon how
4 complex this ultimately becomes. It's a list of 10 major
5 conditions and what does that mean and who got referred.
6 And it says where each person with each condition was
7 treated and who provided care to each person and how many
8 of these procedures where each center performed.

9 What if you have a child with a very rare
10 pancreatic thing? You send them out of network for a
11 specialty surgery that maybe only two people did. It just
12 seems like it's not one of the major priorities of this
13 task force, and there seems to be two very similar if not
14 duplicative --

15 DR. ENTHOVEN: I think people are concerned
16 and patients would like to know if they are very seriously
17 ill and need complicated forms of care, where is their
18 health plan sending them. Maybe there's some other way we
19 can word it, but it seems like there's reasonable intent
20 there. And it doesn't seem like that's a very -- do other
21 members --

22 DR. SPURLOCK: The issue is "major." What
23 does major mean? How does it apply? What about the
24 complexity of a disease? If you want to look at common
25 illnesses or common things where they are sent, that's a
26 different story than major. I think there are data
27 collection issues with this. So I think it's a complex
28 problem that would be difficult to show. You have to do

1 it on a year-to-year basis because it could fluctuate
2 depending on influx of providers in and out of the system.
3 So I do think there's a complexity to it
4 that's not really clear in this recommendation.
5 DR. ENTHOVEN: Bruce, will you bring it back
6 up when we get there?
7 DR. SPURLOCK: I will.
8 DR. ENTHOVEN: Thank you.
9 Next we have Catherine Dodd on consumer
10 involvement.
11 MS. DODD: I'm presuming we skipped over
12 4(e) because it's more controversial. Is that true,
13 Mr. Chairman? 6(e), I mean.
14 DR. ENTHOVEN: Use words, please.
15 MS. DODD: Governmental regulation
16 oversight.
17 DR. ENTHOVEN: We're waiting until we --
18 MS. SINGH: We're not skipping. We have a
19 stack of speakers cards, and we're just trying to work our
20 way through them.
21 MS. DODD: Thank you.
22 Under consumer involvement, section 3, page
23 7. And I really appeal to those of you who are here. You
24 are the eyes and ears of the people who aren't, and this
25 is the only chance for the public to have input on this
26 public process. So there's a lot of weight on you.
27 Page 7 provides three choices for consumers:
28 The plan, the group, and the physician. Consumer choice

1 must also include certified nurse practitioners, certified
2 midwife practitioners, and clinical nurse specialists. We
3 suggest editing that line to say "plan, group, physician,
4 or other health care professional working within their
5 scope of practice."

6 One of the problems in the health plans of
7 today is that people can't choose certified nurse
8 midwives, nurse practitioners, and clinical nurse
9 specialists. So if you truly believe in choice, you'll
10 make that change.

11 DR. NORTHWAY: Where are we?

12 MS. DODD: Page 7.

13 DR. SPURLOCK: Can we have every speaker say
14 which section, page they're on?

15 DR. ENTHOVEN: And the name of paper.

16 MS. DODD: Consumer involvement,
17 communication information.

18 MR. LEE: Slow down. It takes us a minute
19 to flip to it.

20 MS. DODD: 6(g). The one Maureen just spoke
21 on.

22 DR. NORTHWAY: Some of us are slow. We have
23 a lot of weight on our shoulders.

24 MS. DODD: Page 7. Three choices for
25 consumers.

26 DR. ENTHOVEN: We can't formally ratify
27 this. Can we sort of all agree informally we will try to
28 make that a rule? Everywhere there's "physician" we'll

1 put in parenthesis "or other provider working within the scope."
2 MS. O'SULLIVAN: How about without
3 parenthesis? Physician or other provider. No, really.
4 Why parenthesis?
5 MS. FINBERG: Actually, I think we already
6 agreed to that. Why don't we remember to do it.
7 DR. ENTHOVEN: I remember my associates in
8 the defense department when I was working there saying
9 we're trying to paint a moving train. But in principal I
10 think that is accepted that we're going to do that.
11 So, Ms. Dodd, let's not -- could we agree
12 it's an accepted principal. We're going to try to roll
13 that throughout the papers so you don't have to come back
14 for each paper and tell us that anymore.
15 MS. DODD: Thank you.
16 MR. LEE: Telling staff would be a good
17 idea.
18 DR. ENTHOVEN: Is it the same point in
19 regulatory organization, or do you want to talk about
20 something different? I see you have a speaker card for
21 that too.
22 MR. LEE: Would it be possible to flip
23 quickly through that stack so we can group all the
24 comments together so we can stay with it?
25 MS. SINGH: We are.
26 DR. ENTHOVEN: That's already done. Now
27 we're going to have regulatory organization.
28 MS. DODD: This is 6(e). My comments

1 reflect page 5.

2 MS. SINGH: Members, please note this paper
3 has been revised since your receipt. And so you need to
4 refer to the regulatory organization paper that's in your
5 manila folder, not the regulatory organization paper
6 that's in your binder.

7 MR. LEE: The comments from the public will
8 probably relate to the other one.

9 MS. SINGH: That is true. But please keep
10 in mind there's a revised document. And that revised
11 document is also available to the public on the back
12 table.

13 DR. ENTHOVEN: Would you please jump in and
14 say what it is.

15 MS. GRIFFITHS: Mr. Chairman, I have a
16 question, please. If we're going to be working from the
17 revised documents, it would be extremely helpful if we
18 knew what the revisions were. Are they outlined?

19 DR. ENTHOVEN: There is a line in/line out
20 on that.

21 MS. FINBERG: Are they the ones that were
22 contained in the FAX from --

23 DR. ROMERO: Exactly. Nothing new. Just to
24 be clear on that for other members. I found I made some
25 minor mainly technical revisions and also made the
26 treatment of the board versus individual director issue
27 more balanced. Those were the changes. I summarized them
28 in a FAX that went out to you folks a couple days ago.

1 That's the one Jeanne referred to. Those of you who
2 didn't get it, I can outline it later when we discuss the
3 papers more thoroughly.

4 DR. ENTHOVEN: All right. Let's go.

5 MS. DODD: In terms of this, I'll just make
6 one comment that relates to streamlining regulatory
7 oversight and alternative No. 4. We suggest --

8 MR. NORTHWAY: Which page?

9 DR. ROMERO: Section 4.

10 MS. DODD: No. 1, alternative 4.

11 MR. LEE: Page 10.

12 MS. DODD: Thank you.

13 MR. LEE: Prior version.

14 MS. DODD: It suggests putting all the
15 healing arts boards, which I see is amending to be health
16 professional boards, under the regulatory body. I'm not
17 going to call it the OSO. And I would like to suggest
18 that you consider rather than putting all of them under
19 OSO or whatever you're going to call it, put this new
20 agency under the Department of Consumer Affairs which is
21 already set up with an investigatory branch, a consumer
22 complaints branch. It's an extremely effective
23 organization.

24 I would also like to point out that the
25 emergency medical service authority acts completely
26 autonomously county by county in this state and has to
27 interface with managed care organizations and needs to be
28 included somewhere in your planning. Right now they are a

1 lone ranger. And it causes much problems for emergency
2 rooms and critical care units throughout the state of
3 California.

4 And lastly I just want to make the comment
5 that we support this being a public body and not a state
6 department. Thank you very much.

7 DR. ENTHOVEN: Next we'll have --

8 MS. O'SULLIVAN: Not a state department or
9 not an authority?

10 MS. DODD: They have public people.

11 DR. ENTHOVEN: A board.

12 Maureen O'Haren.

13 MS. O'HAREN: Thank you, Mr. Chairman. On
14 the regulatory organization paper; right?

15 DR. ENTHOVEN: Yes.

16 MS. O'HAREN: We're still there. There's a
17 number of alternatives under the issue of how this new
18 department is put together, and I think you combined 3 and
19 4 now as I'm looking at a new draft. I think that we feel
20 that, at least at the outset, this entity should regulate
21 only health care service plans and that anything else
22 should be considered later. But in no event would it be
23 appropriate to regulate a physician office or clinic under
24 the same auspices, and it should only be similar
25 risk-bearing entities that are considered for -- you know,
26 if somebody in the future had to consider this, you
27 shouldn't be assuming to bring in physicians' offices into
28 this framework.

1 I think you know where we stand on the issue
2 of whether it should be a board or a single appointed
3 executive.

4 DR. ENTHOVEN: Maureen, that's my problem
5 with you. You know that we know where you stand, so why
6 take our time on that?

7 MS. O'HAREN: I'm not going to. I said you
8 know where we stand, and we're still there.

9 I think there's some of these
10 recommendations pertaining to allowing medical groups to
11 go to the health care service plan regulator and say, "We
12 don't want the health care service plan to come in and
13 monitor us for quality and solvency. We want you to
14 appoint some outside folks to do it." I think that until
15 we decide where medical groups are regulated, that
16 probably is not appropriate until we can sit down with the
17 medical groups and decide on a streamline situation.

18 We have obligations to our regulators, to
19 the federal government, to NCQA to regulate those groups.
20 And it would be problematic if our medical groups could
21 avoid us and go directly to our regulator and say, "Keep
22 those guys out of our office. Find somebody else to do
23 this." I think we need to take a look at that seriously.
24 Those are my comments.

25 Again, I think the other thing is that if we
26 can do one thing with the streamlining issue, it would be
27 to get DOC and DHS to work together, especially on the
28 provider audits. Because I think here we have two state

1 government entities whose existence blocks from each other
2 that aren't working together on something that is
3 something very burdensome, especially for providers. I
4 think that's one thing that should be clear in this
5 report.

6 DR. ENTHOVEN: Thank you.

7 Next we have Scott SypheX, California
8 Medical Association, who wants to talk about regulatory
9 organization.

10 MR. SYPHEX: I'll keep it brief since all of
11 you know where CMA stands on the board versus a single
12 appointed person, which is to say we strongly advocate for
13 a full-time or a board with a full-time chief executive or
14 chair, however you want to term it. Standard
15 appointments, no designations at this point in terms of
16 what slots they are put into.

17 Just one comment about as you're making your
18 decision on this particular issue. There's a trite little
19 saying that management consultants tend to use with their
20 clients when they are trying to get them to reevaluate
21 their processes and systems, and that is when you're
22 looking at a particular system, they say, "If you do what
23 you've always done, you're always going to get what you've
24 already got." Which is to say that the proposal for the
25 single individual with an advisory board is nothing more
26 than what we have right now with the Department of
27 Corporations and its Shatto advisory committee that most
28 of the people in this room up until the last meeting

1 weren't even aware that existed, which sort of
2 communicates how important they are to the overall
3 process.

4 In any event, once again we support the
5 board concept with a board that is actually functioning
6 and has some authority. Thank you.

7 DR. ENTHOVEN: Next Maureen O'Haren is going
8 to talk about consumer choice.

9 MS. O'HAREN: Thank you, Mr. Chairman.
10 Again, I will be brief. I think you heard from Ann Eowan
11 last time around on the issue of 51 to 100. There are
12 still members of our association that oppose that
13 expansion. There's also a recommendation by Chairman
14 Clark Kerr that there be a group put together to talk
15 about there opt-out proposal, and I think that we would
16 strongly oppose that. I think that there are adequate
17 products in the market to provide that service. And it
18 defeats the purpose of managed care to allow someone do
19 opt-out when they get very sick.

20 The whole purpose of a managed care plan is
21 to manage that care, and the real challenge is when
22 someone is very sick. I think it should be noted that the
23 plans are required by law to provide access to specialists
24 that are not perhaps within the network when the need
25 arises. For example, a friend of mine who's a Kaiser
26 member had a child born with a very rare disease and they
27 requested that Kaiser provide them with a specialist in
28 this area. And Kaiser did so, provided them with someone

1 out of the network because it was such a rare disease and
2 they did not have somebody in the plan with that
3 particular expertise in this very rare disease. So there
4 are accommodations in the law for this.

5 But to require that a plan just basically
6 disband not only is problematic from the point of managing
7 care, but we also have federal law requiring the plans
8 provide 90 percent of the care within their network and
9 you can only have 10 percent out of network. And that
10 would create several problems for the qualified plans.

11 DR. ENTHOVEN: Thank you. Next is Maureen
12 O'Haren on practice of medicine.

13 MS. O'HAREN: I'm sorry about this.

14 I think we continue to oppose the proposal
15 on eliminating prior authorization, especially for
16 catastrophic conditions. I think that the Recommendation
17 1(c) would have to be modified significantly, and I can
18 provide suggested language to the authors of that report.
19 I think the one recommendation that concerns us the most
20 is of course the recommendation pertaining to liability.

21 Our national affiliate, the American
22 Association of Health Plans, commissioned a study on this
23 issue and determined that health care premiums would
24 increase by as much as 12 percent depending on how much
25 defensive medicine or defensive coverage decisions were
26 made because of this expanded liability. I think that's
27 something you need to take into consideration as you take
28 a look at this liability provision again.

1 Otherwise, the formulary proposals are
2 things I think you know we support. And I think the last
3 recommendation regarding the stakeholder group to look at
4 when experimental treatments have become accepted, I think
5 the stakeholder groups listed are not the appropriate
6 groups. I think that you need to create a panel of people
7 who are experts in this area similar to what Blue Shield
8 has done and the process that ECRI goes through. I don't
9 think these groups are the appropriate groups. This is
10 something that is highly scientific and should be
11 determined by experts. Thank you.

12 MR. LEE: Can I ask a quick question. I
13 just got in the last few days results of studies sponsored
14 by Kaiser Family on the same issue in terms of the
15 potential costs of expanded liability. And their
16 results -- I think it was done -- I'm not sure who did it,
17 one of the big firms. Price Waterhouse found premium
18 increases from .1 percent to .4 percent.

19 Are you familiar with this study?

20 MS. O'HAREN: I'm not. And I guess you have
21 to -- the question is whether they looked into defensive
22 costs or coverage decisions where they factored in the
23 unintended consequences down the line. I think if you
24 look at what would be the expected rise in premiums just
25 due to awards, that would be one thing. But if you're
26 looking at what people's behavior is and how they might
27 change as a result, that's something else. I think we see
28 more of that than anything else.

1 MR. LEE: What this other study saw.

2 MS. O'HAREN: Pardon?

3 DR. ENTHOVEN: Peter, you have to remember

4 what Senator Everett McKinley Dirksen said to his

5 colleagues, "A billion here, a billion there. Pretty soon

6 it adds up to real money."

7 MR. HIEPLER: He wasn't talking about

8 lawsuits, though. He wasn't talking about holding someone

9 accountable in lawsuits.

10 DR. NORTHWAY: Are you saying that because

11 it might cost some money, you shouldn't be held

12 responsible for decisions that you might make?

13 MS. O'HAREN: No. I think we are held

14 accountable. There are lawsuits filed against health

15 plans right now.

16 DR. ENTHOVEN: Thank you very much.

17 Catherine Dodd on practice of medicine, the

18 same paper.

19 MS. DODD: H, practice of medicine in the

20 "Findings" section, section E under "Accountability in

21 Practicing Medicine." I'll give you a second to get to

22 that.

23 MR. NORTHWAY: What page?

24 MS. DODD: Page 3, accountability findings.

25 It states that the Medical Practice Act as state law

26 assures that only qualified professionals make medical

27 decisions and goes on to say that the Medical Board is

28 responsible for disciplining individuals. This is true

1 for physicians and physician assistants. But it should
2 also be noted that the Nurse Practice Act also making
3 reference to overlapping functions between nursing and
4 medicine as does the Pharmacy Board. And the Board of
5 Registered Nurses is responsible for disciplining
6 registered nurses if they're practicing dangerous patient
7 care.

8 It would be more accurate to read, "The
9 Healing Arts Practice Act assure that only qualified
10 professionals make decisions regarding patient care.
11 Their respective boards are responsible for regulating
12 licensure and disciplining individuals if their practice
13 is endangering patients. In addition, patients also have
14 redress for negligent action by the providers through the
15 tort system."

16 Under "Recommendation," same document.
17 Essentially I'm making us all more available to be
18 disciplined. Recommendation 1-B on the same document
19 under "Formulary Effectiveness," it makes reference to the
20 importance of flexibility. And again, that's an issue
21 where we're talking about licensed providers. But I think
22 one of the points that's lost there is -- the line about
23 flexibility says, "Flexibility should be built into the
24 process to allow for individual" -- and I'll insert
25 "provider" -- "and patient variation." And I'm wondering
26 if the task force doesn't really mean individual patient
27 variation. Because it's the provider that's choosing
28 medications based on patient needs, not the provider

1 that's choosing medications based on providers' favorite
2 drug company, if you will.

3 I actually think it would take away from the
4 implication that physicians often use drugs that they have
5 been taken out to dinner by the drug company for if you
6 just say that we're making decisions based on what
7 patients need, not to what physicians or providers like to
8 use. It's purely based on if physiological needs of the
9 patient and their disease process. So I would say patient
10 variation --

11 MS. O'SULLIVAN: Could you say what line
12 you're at. We're on page 5, recommendation 1 --

13 THE WITNESS: Page 6 under "flexibility."

14 DR. ENTHOVEN: Page 6 or 7?

15 MS. DODD: 1(b), formulary effectiveness.
16 Thank you. It's the first paragraph, the fourth line from
17 the bottom that begins with the word "flexibility."

18 So if you said that flexibility should be
19 built into the process to allow for individual patient
20 need based on physiology and disease process not on
21 physician provider preference, you would just say
22 flexibility should be built into the process to allow for
23 individual patient variation. I'm just suggesting to
24 take --

25 DR. ENTHOVEN: Some physicians feel they
26 have experience with some drugs and confidence in them.

27 MS. DODD: It's still basing it on the
28 patient's individual needs, not on their preference. The

1 argument from cost containment is that physicians -- I
2 mean, most physicians prefer Motrin over ibuprofen. And
3 Motrin, in fact, is better on some people's GI tract than
4 ibuprofen is. So the physician needs to say or the
5 provider, the nurse practitioner, needs to say, "We're
6 going to order ibuprofen 600 for this reason: For patient
7 need, not for physician preference." I'm merely making it
8 as a suggestion to take the accusations away from the
9 providers who are prescribing. I don't usually try and
10 defend physicians but this is historic.

11 DR. ENTHOVEN: Catherine Dodd on new quality
12 information.

13 MS. DODD: Do I get to go home after this?

14 DR. ENTHOVEN: Yes, you may.

15 MS. DODD: The question is, are you going to
16 give me an "A"?

17 DR. ENTHOVEN: We don't publish the grades
18 until next week.

19 MS. DODD: "Quality Information
20 Development," section 2, Recommendation E, basic safety
21 standards includes a section under 5(a) that acceptable
22 rates of events and outcomes such as infection rates and
23 unplanned readmission rates for inpatient and outpatient
24 care and adverse drug events, et cetera, be established.
25 And we'd like to request that two additional events be
26 used as examples and that the outcomes be added to the
27 suggested list because recent research in four states has
28 proven that these outcomes are directly related to the

1 quality of nursing care in the inpatient setting which has
2 changed since managed care has been implemented.

3 Data on these events and outcomes is already
4 being collected through inpatient unusual occurrence
5 systems, which used to be called incident report systems,
6 so it's not an additional burden in terms of data
7 collection to the institution. Those two unusual
8 occurrences are patient falls and pressure ulcers. They
9 may not seem as significant as a readmission, but when
10 it's your mother who's fallen and broken her hip after all
11 she had was a hernia operation, it's a significant event.
12 And pressure ulcers, as you all know, are not pretty
13 disease processes.

14 MS. O'SULLIVAN: Catherine, can you repeat
15 where you're recommending?

16 MS. DODD: I would add to the list of --

17 MALE VOICE: Page 4 and 5(a).

18 MS. DODD: So you would add patient falls
19 and pressure ulcers to where you're collecting data.

20 DR. ENTHOVEN: Thank you.

21 Next is Maureen O'Haren, vulnerable
22 populations.

23 MS. O'HAREN: Thank you, Mr. Chairman. I
24 think first of all just in reading this paper with the
25 duplication of so many of the recommendations in other
26 areas of the paper, it's hard to read and comment on. And
27 I won't comment on those recommendations that are
28 duplicated in other papers. I will just say in a general

1 sense there's several recommendations that would require
2 the state -- and I'm presuming DHS and PERS are the ones
3 mentioned -- to contract only with plans that contact
4 multiple populations and report outcomes for these
5 populations.

6 DR. ENTHOVEN: I didn't think that meant
7 PERS. I thought that meant DHS.

8 MS. O'HAREN: Then perhaps it needs to be
9 clear.

10 As well as contract only with plans that
11 credentialed providers based on certain sensitivity,
12 cultural competence, and so forth, things that are very
13 subjective and hard to define let alone track. I think
14 these requirements may preclude the state from contracting
15 with health plans that may be smaller, just starting up,
16 not have the resources to put in these sort of
17 sophisticated tracking systems. I think you may preclude
18 some of the plans that have provided care to these
19 populations for the longest period of time. I think this
20 needs to have some serious analysis before this
21 recommendation should be made in terms of what would be
22 the impact on the availability of certain plans, certain
23 plans that heavily involve the safety net provider in the
24 MediCal program. Thank you.

25 DR. ENTHOVEN: Catherine Dodd on vulnerable
26 populations.

27 MS. DODD: Pass.

28 DR. ENTHOVEN: Maureen O'Haren, integration

1 case study on women.

2 MS. DODD: Just to go back a little, Sarah
3 has asked me to let you know that I was commenting on
4 Recommendations 15 and 19 in particular on the vulnerable
5 populations paper.

6 Regarding the integration paper, I think the
7 recommendations that raise the most concern for us are
8 Recommendation 3 which suggests that plans be required to
9 cover out-of-network care. Plans must provide all
10 medically necessary services within the network, and
11 that's required by law. We're talking about integration
12 case study on women.

13 MR. NORTHWAY: What's the tab?

14 MS. SINGH: Tab 6(k).

15 MS. O'HAREN: The notion that plans be
16 required by law to provide care out of network would not
17 be appropriate or consistent with the law. And I think,
18 as I mentioned last time, MediCal plans must always
19 provide coverage for care provided by any provider of
20 family planning services, whether inside or outside of the
21 network. So a lot of these need taken care of.

22 In addition, I think I've expressed our
23 opposition to Recommendation 4 which suggests that all
24 materials be sent to all enrollees as opposed to just the
25 subscriber, the head of household, or the single address.
26 That would be extremely expensive and increase
27 administrative costs rather unnecessarily. Thank you.

28 DR. ENTHOVEN: Thank you. Next is Catherine

1 Dodd, same paper.

2 MS. DODD: Same paper, page 3. This is kind
3 of -- I just want to say it so I'm certain that it gets
4 said. It's a different slant on other licensed provider.
5 It's related to coverage coordination of care, section A,
6 which is the second paragraph, third line from the bottom
7 of that paragraph. It says, "In case of direct access to
8 obstetrics/gynecologist." We'd like added to that
9 "certified nurse midwives and women's health care
10 practitioners." They're specially trained women's health
11 providers.

12 Same paper, section 5, recommendation 5(b).

13 DR. ENTHOVEN: Certified nurse midwives
14 and --

15 MS. O'HAREN: Women's health nurse
16 practitioners. They have a specialty in that area as do
17 obstetrician/gynecologists.

18 Page 6, 5(b) relating to managed care
19 organizations encouraging generalists who wish to provide
20 primary care to women to demonstrate competency in the
21 basic aspects of gynecological care. We're pleased with
22 the suggestion, but we believe that women's health is more
23 than just a list of exam tasks and would like to request
24 that the competency of sensitivity to the unique needs and
25 concerns of women be added to that.

26 There's a difference between knowing how to
27 do a pelvic exam and doing a pelvic exam that respects the
28 dignity of the person that's on the table in the stirrups.

1 So it would be adding to the list of competency
2 "sensitivity to the unique needs and concerns of women."
3 Under 5-C, it includes -- we would like to,
4 just for editing clarification purposes, request that
5 certified nurse midwives be substituted for "other
6 appropriately credentialed advanced practice professionals."
7 DR. ENTHOVEN: This is 5(c)?
8 MS. DODD: 5-C.
9 Then lastly, under No. 8 we'd like to
10 request that the words "prenatal" and "postnatal" be
11 removed because these terms refer specifically to birth
12 and therefore would not include therapeutic abortion.
13 Using the word "perinatal" covers all pregnancy-related
14 services. So No. 8 would read, "Offer coverage of the
15 full range of perinatal services." Or if you wanted to,
16 you would say, "Offer coverage for the full range of
17 pregnancy-related services," and that would eliminate any
18 confusion regarding access to legal therapeutic abortion
19 services. Thank you.
20 DR. ENTHOVEN: Maureen O'Haren on dispute
21 resolution. As far as I can tell, that's going to
22 complete the Maureen and Catherine show.
23 MS. O'HAREN: Marty Gallegos put up with me
24 all year long, so don't feel too bad.
25 MS. SINGH: 6(f).
26 DR. ENTHOVEN: Where is Marty?
27 MS. O'HAREN: He's probably caught in the
28 fog.

1 The dispute resolution paper has been
2 changed a lot, I think, to accommodate a lot of the
3 concerns and the suggestions that we provided. I think
4 that we still have some concerns that the suggestions on
5 the public reports go too broad. And this bullet that
6 says, "Summary of the reasons decisions were upheld or
7 overturned including the basis upon which decision were
8 reached for particular types of complaints" --

9 MR. NORTHWAY: Page?

10 MR. LEE: Page 6, top of the page.

11 MS. O'HAREN: 3(i), recommendation 3(i).

12 I don't think that the DOC report could
13 ever -- I don't think you ever generalize these reasons
14 that much. I don't think the DOC report could ever do a
15 line-by-line commentary on each complaint and what was
16 done with it. I think this goes a little bit too far in
17 terms of what could be done on the sorting by plan and
18 medical group as well and might significantly increase the
19 cost and complication of any sort of data report.

20 I think there's a lot of effort and
21 initiative under way in the data collection area. I think
22 you're all aware of the initiative that our association is
23 involved in, and that will greatly improve the services
24 that people receive at the point of service. And I think
25 that money should be spent there rather than on this area.
26 Thank you.

27 DR. ENTHOVEN: Thank you very much.

28 We now have a quorum. So without limiting

1 myself to three minutes, I'll just offer a few opening
2 remarks.

3 I'd like to begin by saying I think we have
4 made a tremendous amount of progress to date, especially
5 when you consider the obstacles that we faced at the
6 outset of this task force. We were given a very short
7 time, and we're all suffering from that. We have to deal
8 with a very complex and controversial set of issues. And
9 in many cases, we've had to do a lot of learning to get up
10 to speed on that.

11 I suspect but can't prove that I'm not the
12 only one who would not have read the Knox-Keene law from
13 cover to cover but for the task force. We have 30 people
14 with very diverse points of view, strongly held. I think
15 there was some mutual suspicion at the outset. So it
16 isn't surprising that many people had low expectations of
17 what this task force could accomplish.

18 In fact, if we stay on the course projected
19 in the last meeting, we'll reach majority support for
20 close to 100 recommendations, which when taken together
21 will add up to a far-reaching change in the regulatory
22 system, the economic incentives, and the general
23 functioning of the managed care industry in California.

24 We still have a few points of controversy
25 ahead of us, and I've been getting communications on
26 those, of course. But whichever way we go, we'll still be
27 able to recommend a very substantial reform package. So I
28 do want to encourage you all to focus on the areas of an

1 extent of agreement and not become depressed or
2 pessimistic over a few points of disagreement.

3 I think we have had a great deal of
4 opportunity to air the issues and to listen to the general
5 public and hear from leading experts. There are areas
6 where there is disagreement, sometimes because people have
7 different estimates of what the consequences of actions
8 are or where people lack important pieces of information
9 like, "For this or that change in malpractice liability,
10 what would the cost implications be?" It's not easy to
11 quantify.

12 But I do believe that we all share the
13 important goals of a health care financing and delivery
14 system in California that consistently delivers high
15 quality care in a way that is considerate and respectful
16 of people and their dignity, their diverse needs,
17 convenient, user friendly, affordable, widely accessible,
18 and fair. I do believe we all support that set of goals.

19 If you read through it, as I guess we've all
20 had to now, you see that we really have a lot of ideas
21 here. I expect today the task force will vote to
22 recommend a new regulatory authority; a number of measures
23 aimed at improving the market, the way it works; measures
24 recommending public purchasers starting there; and then
25 all major purchasers to do risk adjustment, et cetera. I
26 won't review the whole thing in the interest of time.

27 In the coming week the staff, under my
28 direction, will be revising the papers in accordance with

1 the decisions made by the task force today and tomorrow.
2 One of the questions we'll face is the order in which to
3 present the summary recommendations. We propose to
4 question you with a delphi process and ask you to indicate
5 the order in which you would present the topics. And then
6 we'll just add it up and do the votes that way. So we'll
7 ask everybody for all these topics to put the numbers.
8 This should appear first. This is not a matter of
9 importance or of how important they are; it's just a
10 matter of in what order they should appear.

11 Jeanne and I were talking about this
12 yesterday and she raised the question whether that was
13 worth the effort or whether the staff and I could be
14 trusted to figure out what made sense. We would group
15 things by consumer protection, various categories. So
16 making competition work, quality of care, empowering
17 consumers, regulatory organizations would have some groups
18 and then subgroups.

19 So let me just ask first by the show of
20 hands whether we're using the delphi method or leaving it
21 to the staff.

22 Jeanne, did you want to comment?

23 MS. FINBERG: Yeah. I want to say
24 something. My suggestion was -- it sounded like what the
25 chairman had in mind was putting the regulatory paper
26 first because of logic, and that sounded like something
27 that probably people would agree on. But that should be
28 discussed. But after the first one, I didn't think the

1 order was necessarily that critical and that perhaps the
2 chair and the staff could do that.

3 They are going to present an executive
4 summary, which we'll have the opportunity to review. And
5 it seemed to me that rather than the order of the papers,
6 the prominence in the executive summary would be something
7 people would be more concerned about. And I thought a
8 vote about order might produce some odd results that no
9 one would really be satisfied with. So that was my
10 suggestion. But I do think the first paper is probably
11 important and that there should be some brief discussion
12 about that to see if we could agree.

13 DR. ENTHOVEN: Thank you.

14 Nancy.

15 MS. FARBER: It would seem logical that you
16 order the papers in the sequence that the law mandated us
17 to explore subjects. And I recognize that we have papers
18 supplemental to that and they could be identified. After
19 that, I don't think it's important what order the
20 supplemental papers go in. But it just makes sense that
21 we were given a legislative mandate, and we should follow
22 it.

23 DR. ENTHOVEN: I think that was our intent.
24 We'll start with the mandated papers. Then I think, as
25 Jeanne was saying, then we'd go to regulatory
26 organization. It's going to be kind of on everybody's
27 mind and probably is a logical place to start. Then
28 quality of care, consumer protection, et cetera.

1 MS. FARBER: I've forgotten the order in
2 which the legislature gave us our commission.

3 DR. ENTHOVEN: We'll go right back to the
4 law. That's a good idea. We do have that.

5 Is it the task force contention to leave it
6 at that and we'll work it out and of course this will come
7 back to you?

8 MR. LEE: I'm fine with that. The question
9 that Jeanne made an allusion to that maybe you were about
10 to talk about is the process by which we'll get a review
11 and comment time on the draft executive summary and also
12 on the background papers. We are going to vote on them,
13 but there have been a lot of changes that we think may be
14 incorporated in them. It would be helpful to have another
15 look at them to see if they are and to be able to get back
16 to staff to make sure the changes are incorporated.

17 I'm much more concerned with the executive
18 summary and that we have a back and forth opportunity to
19 get feedback so we don't show up on January 5 and have a,
20 "My God, this is totally off." Nobody wants to have
21 January 5 be unpleasant.

22 DR. ENTHOVEN: Let's see. We were thinking
23 that on December 22 we would FAX out to everybody --

24 MS. SINGH: FedEx.

25 DR. ENTHOVEN: FedEx the draft of the
26 chairman's letter and the executive summary.

27 MS. SINGER: Can I actually add? What we
28 were thinking is that the staff who would do a first draft

1 of the summary would work with the ERG members as a first
2 round to get some agreement as to what those executive
3 summary sessions would look like. And then that would be
4 the version that would get FedExed out to people on the
5 22nd. And if people wanted to give feedback before that
6 on the executive summary and any of the other papers
7 between then and January 5, that would be fine.

8 MR. LEE: Just to clarify. So it's going
9 out on the 22nd. But then with people trying to get
10 comments back in, something different would be revised
11 coming back on January 5. Or is that just so we have it
12 before the 5th?

13 DR. ENTHOVEN: I think it's so you have it
14 before the 5th.

15 DR. RODRIGUEZ-TRIAS: Where is the chance
16 for input?

17 DR. ENTHOVEN: We'll use the 5th to discuss
18 it.

19 MS. SINGH: The January 5 task force will be
20 charged with adopting the executive summary and
21 transmittal statement. So you have that entire day to
22 discuss that. Trying to get comments back and forth from
23 members over the Christmas holidays I think will be
24 difficult for both members and staff. And mail issues
25 also.

26 DR. ENTHOVEN: I think a lot of people are
27 going to be away during that time. Let's see. Sarah, I'd
28 appreciate it if you'd just stay at the table now that

1 it's been vacated by Catherine and Maureen.

2 MS. FINBERG: Does that mean that the report
3 is not going to go out on January 5? If we're talking
4 about language and finding the statement, then it can't
5 really go out the door; right? We need to see another
6 draft.

7 DR. ENTHOVEN: Peter raises another
8 question. What about the background paper?

9 MR. LEE: I would request those go out on
10 the 22nd as well.

11 DR. ENTHOVEN: Sarah, are we going to be in
12 a position to see the background paper and not just the
13 front paper?

14 MS. SINGER: That's the intent.

15 DR. ENTHOVEN: We will be in a position to
16 send those out also?

17 MS. SINGER: Yes. That's the plan.

18 DR. ENTHOVEN: Okay. Then Nancy Farber.

19 MS. FARBER: My concern about going back
20 just to the commission members that participated in the
21 original development of these plans is we've taken these
22 papers well beyond that point, and we've gone through
23 revisions that were made by people that didn't participate
24 in the original development. We've taken straw votes.
25 And my hope and expectation would be the final drafts
26 reflect those discussions where the straw votes were taken
27 and not go back to the original documents.

28 Nancy, when you say you're going to consult

1 the people that were originally involved in the
2 development of the papers, it's of significant concern to
3 me where substantial amendments were made to those papers
4 is you don't go back. You're not planning to go back
5 apparently at this point to the people who made those.

6 MS. SINGER: I should correct myself. If
7 there's a person who is responsible for a particular new
8 addition too, we'd also go back to those people. There is
9 a limited amount of time in the next week to get
10 everything done, and we're trying to be as efficient as
11 possible. In addition to that, everyone will get the
12 versions that we complete as of the 19th on the 23rd, and
13 we'll have opportunity to get feedback.

14 DR. ENTHOVEN: For example, what we say in
15 the executive summary about consumer information is going
16 to have to be boiled down to a paragraph of several lines.
17 And we would expect to consult with Jeanne Finberg, get
18 her acquiescence that this appears to be a fair summary.
19 I think that's the best we can do in the short time
20 available.

21 MS. SINGH: Members, just to very quickly
22 clarify, remember the executive summary is simply a brief
23 summary of the main report, and the main report is the
24 verbatim findings and recommendations that hopefully at
25 that time will have been adopted by the task force. We're
26 not talking about a brand new document that's not been
27 reviewed and discussed by the public and this body.

28 DR. ENTHOVEN: Let's see. Maryann

1 O'Sullivan.

2 MS. O'SULLIVAN: Two things. One is Peter
3 was asking about the more lengthy background papers coming
4 to us to look at. I want to be sure that they are not
5 going to be characterized as having been reviewed by the
6 task force, the background papers. Those are things done
7 by staff.

8 DR. ENTHOVEN: That's right.

9 MS. SINGH: It will be in the appendix.

10 DR. ENTHOVEN: We have a little ambiguity
11 here if they are characterized as having been done by the
12 staff. I don't think on January 5 we're going to have
13 time to do a word-by-word review of all of them.

14 MS. O'SULLIVAN: All I'm saying is Peter
15 said, "Can we have them?" What I don't want is for them
16 to appear in the second document as having been reviewed
17 several times by task force staff or anything like that.

18 DR. ENTHOVEN: No. Absolutely not.

19 DR. ROMERO: The title of that volume will
20 be something like "background materials."

21 MS. O'SULLIVAN: My other question is about
22 this language that we've been talking about that maybe on
23 the cover of the document that says "The Task Force" --
24 you know, there were a lot of important things that we
25 considered but didn't fully consider, and there are things
26 that never came under consideration because of time
27 constraints.

28 DR. ENTHOVEN: We don't mean they are not

1 important.

2 MS. O'SULLIVAN: Yeah. Can we come to some
3 agreement about what's on the cover of the document?

4 DR. ENTHOVEN: I refer to that in our group
5 as Maryann's paragraph.

6 MS. O'SULLIVAN: Right. I'd like to see
7 Maryann's paragraph sometime.

8 DR. ENTHOVEN: There's going to be a pair of
9 paragraphs. There's Maryann's and Alain's paragraph.
10 Alain's is going to say, "We didn't have the time or
11 resources to evaluate the costs of these recommendations.
12 And cost is, of course, an important issue because of its
13 relationship to uninsurance," or something like that. I
14 was thinking that that would appear in the executive
15 summary but also prominently in the chairman's letter,
16 perhaps right up close to the beginning. "We had to work
17 within a short period of time" and a few things like that,
18 and then these points. So you will have it. It will be
19 there.

20 MS. O'SULLIVAN: Somewhere up in the
21 executive summary?

22 MS. SINGH: Members, this is something you
23 agreed to at the last meeting was to put that paragraph in
24 the executive summary. So I think this has already been
25 addressed at this point in time.

26 MS. O'SULLIVAN: When are we going to see
27 that paragraph?

28 MS. SINGH: You'll see that with the

1 executive summary.

2 DR. ROMERO: Maryann, you may recall I
3 scribbled something out at the last meeting and showed it
4 to you. I haven't changed it since that time.

5 MS. O'SULLIVAN: Maybe we can talk about it
6 a little bit.

7 DR. RODRIGUEZ-TRIAS: I guess I have some
8 concerns about the report reflecting more of our process
9 and discussion that wouldn't be on the mandate and to
10 ensure that in that executive summary in the introduction
11 that we acknowledge that there has been a great deal of
12 concern around this table about being uninsured, even
13 though that was not our mandate. But I think there has to
14 be a framework that addresses that.

15 DR. ENTHOVEN: I would like to use that as
16 the main example in Maryann's paragraph and possibly even
17 have a little paragraph about that, about the present
18 situation leaves a lot to be desired, doesn't make sense.
19 And we can work out a paragraph about how that might --

20 DR. RODRIGUEZ-TRIAS: Fine.

21 The other concern I have is that --

22 DR. ENTHOVEN: I just say that I might even
23 lift language from two or three articles that I've written
24 in the past that were proposals for Universal Health
25 Insurance and why we ought to try to get there.

26 MS. O'SULLIVAN: I care very much about this
27 issue but I don't want that paragraph to be that there
28 were other issues that aren't to do with managed care.

1 There are a lot of important managed care issues that
2 weren't considered also. But the uninsured wasn't
3 considered as fully as it should have been.

4 DR. ENTHOVEN: Maybe it's better not to get
5 into that.

6 Helen.

7 DR. RODRIGUEZ-TRIAS: Let me restate my
8 point. I know that there has been a great deal of concern
9 around this table on various occasions about the fact that
10 we are not discussing the uninsured. And I think
11 certainly the way Alain is thinking of approaching it
12 seems to me to cover that. And that is to say yes, this
13 is a major issue for California which has to be faced
14 sooner or later, and possibly sooner. So just to say
15 that. Because I would feel -- so I think that's fine.

16 The other point though is I've got a lot of
17 concern about the style of the writing and about even the
18 grammar. And I'm sure that one of the very fine writers
19 on staff is going to do some sharp copy editing of it.
20 And I hope that that makes the language more readable and
21 understandable. I think it's very difficult for people to
22 read these recommendations and understand what's being
23 said.

24 DR. ENTHOVEN: Helen, I agree with you.
25 You've heard the expression a camel is a race horse
26 designed by a committee. And in some of these late night
27 drafting sessions where everybody is throwing in phrases,
28 okay, and so forth, we get some pretty poorly drafted

1 paragraphs that cause me a little discomfort as I've gone
2 back and read them. I think, "Oh gosh, we used 'which'
3 when we should have used 'that.'" We could have simplified
4 this." But my problem is I don't think we have license to
5 do that. I think these were finally negotiated treatise.
6 And to my regret, I think we're stuck with the
7 ungrammatical --

8 Bruce and then Peter and then Diane.

9 DR. SPURLOCK: Thank you, Mr. Chairman. I
10 just want to at this point make public what I've been
11 talking with Phil Romero about. It's based on what you
12 kind of alluded to in some of your conversations and your
13 comments. The chairman recognizes that we're going to
14 have probably upward of 100 recommendations and also that
15 many of the recommendations we don't have an adequate cost
16 analysis for, primarily because we don't have the
17 resources and ability to do that in the task force.

18 And I made this point a couple meetings ago
19 and I want to bring it back to the task force, that in a
20 situation where we don't have cost analyses and where
21 we're making so many recommendations, we essentially have
22 created a moral hazard from an economic standpoint. I
23 think what I like to see happen on January 5 and recommend
24 is that we go through a process of prioritization so that
25 every one of the 100 recommendations is not necessarily
26 viewed as equal. It doesn't limit people from looking at
27 those recommendations and using them for their own
28 political and other purposes, but it does allow us as a

1 task force to make a statement what we think are the most
2 important, especially if we're going to spend other
3 people's money in the process, so that we can say these
4 things or more important than other things, much like what
5 happened in Oregon when Oregon developed a system by first
6 talking about what kind of health care is best. They
7 actually did a prioritization process because they could
8 not cost out every little detail of all of those
9 recommendations.

10 So I think the simple process that we've
11 been working on would be easy enough to develop a priority
12 mechanism for the topics of the task force.

13 DR. ENTHOVEN: Thank you. I'm not sure,
14 Bruce. I think that makes sense. I'm not sure what to do
15 about it. I think we'll have to say we'll think about it.

16 Sarah, you have something?

17 MS. SINGER: I just wanted to call your
18 attention to a list we put in your package based on the
19 comments we got last time. We tried to make four
20 different sets. One looks at miscellaneous and voluntary
21 initiatives, groups them all together; one looks at blue
22 ribbon commissions, other working groups and committees,
23 advisory groups and such; another looks at new pieces of
24 legislation, new regulations and new government programs;
25 and the last one looks at new data information requests.
26 We tried to break down all the recommendations into those
27 lists so that you could see them.

28 Bruce, I'd be happy to work with you on

1 thinking through how we might create a prioritization
2 process that would work. We've been spending a lot of
3 time thinking about it and have not figured out how to do
4 it efficiently and effectively. But if we can, we will
5 spend some time on it.

6 DR. ENTHOVEN: Peter Lee.

7 MR. LEE: A couple things in response and
8 then hopefully to get us rolling down the path.

9 As much as I may have a problem with the
10 grammar, nothing that comes out hopefully at the next
11 meeting will have any changes because while things did in
12 between the last meeting, we had straw votes --

13 DR. ENTHOVEN: Peter, I just said that.
14 Just so we understand, we don't have any license on that.
15 I think the executive summary where we're going to have to
16 take some of these where we're going into the punch lines,
17 we'll have to have license to do that.

18 MR. LEE: On cross-referencing, it really
19 does relate to this. It's really helpful. I'm concerned
20 in many points in the report where we sort of make
21 cross-reference but don't necessarily incorporate a
22 recommendation in one place or the other. I think a lot
23 of these, so to speak, chapters stand alone and will be
24 referred to alone. And I mean, I would encourage staff --
25 and this may be something to vote on, I'm not sure -- that
26 if something is cross referenced actually at the end of
27 that section, include it in full.

28 It would be a few extra pages. I think that

1 many of these sections I think people would use them. I
2 know I do very often when I look at other reports. I look
3 at one section and that's the only section I may get. So
4 I'd encourage thinking about at the tail end there might
5 be five recommendations specifically and here are eleven
6 others that have findings related to them in other papers.
7 Here's what they are in full here. So it's a restatement
8 that I think would be helpful.

9 The other suggestion -- and it really does
10 relate in terms of where I think we have to have some time
11 potentially tomorrow to go back through where we need to
12 have integrated cross-reference, particularly to panels.
13 I think this grid was very helpful from my read. Some of
14 these aren't recommendations for panels, but some very
15 clearly are. And it seems like it's very close to the
16 exact same thing coming out of two different groups. I
17 think if that's the case, we should be clear saying, "We
18 recommend that there be a panel that, for instance,
19 develops standards for evidence of coverage." It's the
20 same panel referenced in consumer information and in
21 standardization of benefits or whatever rather than make
22 it -- I think that we should acknowledge that it is the
23 same animal if it is. In a couple of them, I think they
24 are. And I think that maybe staff or some members can
25 work on that tonight so tomorrow we can agree that it's
26 here's the seven panels --

27 DR. ROMERO: Seven not ten.

28 MR. LEE: Yeah. A number of these are

1 encouragements to collaborate and others are the same
2 group. So we should say the same group should be doing
3 these three things or these two things.

4 DR. ENTHOVEN: Sarah, do you have any
5 comment?

6 MS. SINGER: We'll do it.

7 MR. LEE: And a procedural question. Is the
8 order we're going through things on the agenda we got, or
9 is there some other order?

10 DR. ENTHOVEN: I'm going to get to that.
11 It's kind of shifting around based on various
12 considerations here.

13 Diane Griffiths.

14 MS. GRIFFITHS: My question and my comments
15 are kind of caught between Helen's concerns and Peter's
16 concerns. While I'm concerned, as I'm sure many members
17 are, about the prospect of recommendations and language
18 being changed, I'm also concerned -- I share Helen's
19 concern that some of the ways in which the documents are
20 drafted are so sufficiently unclear that it will affect
21 the credibility and the meaning of the recommendations.

22 I'll just cite one example that to me has
23 troubled me throughout reading all these documents until
24 3:00 in the morning this morning. If you look at 6(g),
25 the consumer involvement section, I'm looking now at pages
26 3 and 4. This issue, this piece of unclearness, if you
27 will, affects the meaning of what we're doing here, and
28 it's a substantive issue.

1 In these paragraphs, these recommendations
2 listed here, we refer to the state agency is charged with
3 oversight of managed care. And of the paragraphs -- I
4 might add that in another sections we use a different
5 phraseology. So I would think it would be useful to use
6 the same phraseology, whatever it might be.

7 But the substantive point on this one that I
8 wanted to make is that in some of these paragraphs we
9 refer to "the state agency being charged with oversight of
10 managed care, currently DOC and DOI." In others we refer
11 to using the same phraseology, "state agency charged with
12 oversight of managed care" and we say "currently DOC."
13 And there's a clarity issue about whether when we refer to
14 the jurisdiction of these entities, we're talking about
15 just DOC or DOC and DOI.

16 And then of course the substantive issue
17 which Maureen touched on of whether we're talking about
18 only the Knox-Keene plans or other entities as well.

19 DR. ENTHOVEN: Yes.

20 MS. GRIFFITHS: I think that, for one, is an
21 issue of inconsistent phraseology that we ought to try to
22 resolve. And there may be others as well. That's just an
23 example.

24 DR. ENTHOVEN: I think you've got a good
25 point. And the problem is you can't have one
26 cross-cutting rule like we adopted for physicians and
27 other licensed providers practicing within their legal
28 scope of practice or whatever it was because here

1 sometimes it really is relevant to DOC only and sometimes
2 DOC and DOI. For example, on the example you just put
3 your finger on on page 4 of that paper, I see it says
4 "currently DOC or DOI could cause to be created a super
5 directory." Actually the super directory is I think --
6 no, maybe not ambiguous -- but it is irrelevant to DOI.
7 But I suppose if there's an at-risk insured plan with
8 preferred provider components, then I suppose that is DOI.
9 So it would be DOI.

10 We will have to think on each case carefully
11 as to what does make sense. Good point.

12 J.D. Northway. Then I think we should
13 not -- we have to move forward.

14 DR. NORTHWAY: Just some comments on the
15 grammar thing. I think we should look -- I don't want to
16 change (inaudible).

17 I'd like to follow up on what Bruce talked
18 about. And I sent a letter to Alain and to Phil. Because
19 we have talked about a lot of things that add cost, I
20 think we should add something in there that these added
21 costs should be shared by all players in this regard, some
22 by the payers, some by the plans, and obviously some by
23 the providers. But as I listen to our conversations, I
24 hear that the payers don't want to pay any more and the
25 plans don't want to reduce their profits. The only people
26 left then are the providers, and I think that's fine. But
27 the providers have also been squeezed pretty hard in the
28 last few years.

1 I'd like to see us talk a little bit about
2 minimal medical loss ratios so people know when they are
3 putting money into premiums that a certain percentage of
4 that, preferably a high percentage of that, is going to
5 medical loss.

6 DR. ENTHOVEN: I think we now need to move
7 forward. Has the staff passed out the proposed adoption
8 schedule?

9 MS. SINGH: They will at this point.

10 DR. ENTHOVEN: Would you pass out the
11 adoption schedule.

12 MS. SINGH: Members, what staff is passing
13 out to you right now is a document called "Task Force
14 Findings and Recommendations Sections Adoption Schedule."
15 There were copies of this provided on the back table for
16 the public and this will also be made available on our web
17 site. Basically it lists all the findings and
18 recommendations that the force will be acting on. There's
19 a column that indicates when that document has been or
20 will be discussed by the task force.

21 The italicized bold print indicates our
22 proposed dates. There's also a column for adoptive task
23 force meetings, and then whether or not the document has
24 been finalized and is now available to the public. This
25 document will give you the order of the business today.

26 MS. FINBERG: You know, that sort of goes
27 back to the question I raised about the executive summary.
28 We're going to be working on that on January 5. And I

1 guess I was hoping it would go out the door on that date.
2 For a lot of the reasons that have been mentioned, it
3 would be good to have a careful review, grammar check, et
4 cetera. So I don't know if -- this chart doesn't preclude
5 that, but it sounds like our intent is to finalize that on
6 January 5. And I'd like to suggest that we actually don't
7 send it out the door on that day. The reason being that
8 we're all very vested in the executive summary because
9 that's going to be the document that's going to represent
10 this task force. If we are working on it by committee on
11 that day, it will be very difficult for it to represent
12 our best product.

13 DR. ROMERO: Jeanne, I agree with you. And
14 anticipating that, my notion, my hope is that on January 5
15 the executive summary is approved with relatively minor
16 changes which staff can make within a few days thereafter.
17 So the executive summary will be available for
18 distribution by, to pick an arbitrary date, January 10 or
19 something like that.

20 MS. FINBERG: Then would it like be
21 overnighted to everyone again? Like how does that work
22 procedurally?

23 MS. SINGH: Members, the intent here is
24 you'll discuss the executive summary at the January 5
25 meeting and then adopt it. Perhaps there will be
26 amendments just as there oftentimes are amendments to the
27 findings and recommendations sections that you review.
28 The executive summary will be sent to you with the main

1 report after X amount of days. I can't speak to how many
2 days it will take for us to copy those documents and get
3 them out. That will sort of be referred to as kind of a
4 preliminary document. And then the formal glossy bound
5 copy will be sent out probably early February just because
6 of the vendor and the printing process. We'll have
7 several hundreds of pages.

8 MS. FINBERG: My question was going to sort
9 of what happens in between the one that's sent out and the
10 glossy one in terms of an opportunity for review and
11 comment? In other words, if the staff made a mistake and
12 left out the word "not," which I know they wouldn't do.
13 But there are things. People are very vested in
14 particular word choices here.

15 MS. SINGH: I can comment. The staff will
16 be reviewing the transcripts to a T. If you'll note, we
17 actually have been doing that with all the recommendations
18 that have been adopted thus far so that they accurately
19 reflect the statements made that day. If there was some
20 inadvertent error that was made, I guess that we would
21 appreciate that comment right away. But we can't really
22 make any changes, any substantive changes, to that
23 document after January 5 because you need to have the
24 majority of the task force members in agreement with any
25 type of change. Typographical errors and things of that
26 nature can be changed in the summary, but no substantive
27 changes can be made.

28 MS. FINBERG: Then it sounds like I would

1 suggest a change because that seems problematic to me. I
2 think January 5 sounds like a very substantive working day
3 on a very important document. And I think all of us need
4 to review it. I'm not expecting to make major changes. I
5 don't want to. But it's the most important document we're
6 doing. And on the papers and using the transcripts, there
7 have been mistakes. It's a lot of papers. It's very
8 hard. The staff is working very hard. I know there are
9 things that were said that weren't done exactly right.
10 That always happens. And I think we just need to give
11 ourselves the extra time on the executive summary because
12 it's so important.

13 DR. ENTHOVEN: I don't understand, Jeanne,
14 exactly how would we do that if we try to spend the 5th
15 fine tuning and then agreeing on the language, you're
16 saying afterwards we should go back over it and
17 renegotiate the words?

18 DR. ROMERO: What I'm interpreting is that
19 the staff will implement any amendments on January 5.
20 We'll send it out for comments or send it out for you
21 folks to check our work, in essence. We may make
22 mistakes. And Jeanne, I'm hearing that you want an
23 opportunity to look over our shoulders to let us know if
24 we made any mistakes so that we can fix it before the
25 executive summary goes out final. Is that fair?

26 MS. FINBERG: That's right.

27 DR. ENTHOVEN: After January 5 we do the
28 fix, then we recirculate that for one final review.

1 MS. FINBERG: Is there a way we could check
2 off and send it back? Is that legal?

3 MS. SINGH: Members, again we can certainly
4 send out the adopted executive summary for members to
5 review to make sure our work accurately reflects what
6 happened. And members, if there's an error in there, they
7 can note that and send it back to staff. You have to
8 realize that unless that's a very minor clarification type
9 of an error or a technical error, we cannot make that
10 change unless this body meets again and that change is
11 adopted by a simple majority of this task force.

12 What we can do, for example, if you point
13 out there's an error, we can cross-reference it with the
14 actual transcript itself and notes. And if the error
15 you're contending is not found or documented in our
16 background information, transcripts and so forth, we won't
17 be able to make that unless this body comes back. And
18 basically, members, that's just our process. That's the
19 way our bylaws and rules are established.

20 DR. ENTHOVEN: Peter, I really need to move
21 on. Is this really pressing?

22 MR. LEE: Well, it's critical due to our
23 timing. It really relates -- this is the first time we've
24 seen this order. Some of this was prepared in a totally
25 opposite order. So one of the questions I was going to
26 raise was on the public perception paper. I would like to
27 raise it now. I really don't think it's appropriate to
28 vote on a public perception paper because I can't say all

1 the findings, the research done, the survey methodology,
2 it's a very different animal than everything else. Given
3 that, it seems that -- I don't know if other task force
4 members agree. If we aren't going to vote on it, we don't
5 need as much discussion time on it. That frees up more
6 discussion time as we allocate time on other areas.

7 As we received it, it's a technical paper
8 that people may disagree on the interpretation. But it's
9 not something that I think I could vote "is this a survey
10 pool or that the survey pool."

11 DR. ENTHOVEN: I'm assured by my
12 parliamentarian that in order for this to appear in the
13 report, there has to be an affirmative vote by the task
14 force that this should appear.

15 MS. SINGH: Or what you could do, members,
16 again, we had a very lengthy discussion -- which I don't
17 think it's appropriate to get into that again -- on the
18 process of the report. The members voted that any paper
19 that is not mandated by AB 2343 that that finding and
20 recommendation section be included in the main report and
21 that all of those documents be voted on by this task
22 force.

23 What the task force can do by motion today
24 is it can be moved and seconded and then adopted that the
25 public perceptions findings not be voted on. They do not
26 require adoption for inclusion in the main report and can
27 still be included. That can occur today.

28 MR. LEE: That's what I'm moving that we do

1 so we don't have extensive discussion on it then have an
2 introduction that says, "Unlike the other papers, this was
3 not voted on because it's a technical paper. But it's
4 important to provide data to frame the rest of volume 1."
5 So that's a motion.

6 DR. ENTHOVEN: That's a motion. Is there a
7 second to that motion?

8 MS. FINBERG: I second.

9 MS. BOWNE: I want to speak to that issue.

10 DR. ENTHOVEN: Jeanne seconded it. Would
11 you restate the motion.

12 MR. LEE: The motion is that we include the
13 public perception paper in volume 1 but it have a caveat
14 that it was not voted on like all the other sections of
15 volume 1. And hence, that we also don't allocate time for
16 talking about it so we can talk about the issues that have
17 recommendations and findings.

18 MS. SINGH: Basically the bottom line is
19 that it does not require task force adoption for inclusion
20 in the main report.

21 MR. LEE: Exactly.

22 MS. BOWNE: I'd like to speak specifically
23 to that. I would only be in agreement if you would accept
24 an amendment that forget the summary, put in the entire
25 background paper. The whole piece is 26 pages. If you
26 take out the summary which is recapping a part of it,
27 you'd have about 20 pages. Because I think that having
28 the charted statistics that are given in the main body of

1 the paper lends to interpretation. If we have the actual
2 statistics in the body, I think that we will be much
3 better served and we can avoid disagreement because the
4 summary has interpretations of those statistics.

5 So I would be for this motion if we can
6 amend it to say the whole paper.

7 MR. LEE: I consider that a friendly
8 amendment to not include the executive summary but to have
9 in volume 1 no summary and the paper.

10 MS. SINGH: So the motion on the floor at
11 this point -- I'm sorry.

12 MS. FINBERG: I don't know. I agree with
13 including the whole paper whether you take the executive
14 summary off or not. I'd have to reread it to see if that
15 makes sense or not. I'm a little concerned about that.
16 But the idea of including the whole paper is fine with me.

17 DR. ENTHOVEN: It's not taking it off; it's
18 just the whole thing.

19 MR. LEE: Include the whole thing.

20 MS. SINGH: Is there any objection to that,
21 to Ms. Bowne's suggestion?

22 MS. FARBER: I'll call the question. Let's
23 vote.

24 MS. SINGH: Those in favor of adopting this
25 motion please raise your right hand. Those opposed? The
26 vote is 20 to 1. The motion passes. Therefore, the
27 public perceptions paper in its entirety will be included
28 in the main report without the requirement that it be

1 adopted by this body.

2 MR. LEE: People can still make comments to
3 maybe clarify language, but that's sort of staff
4 background comments that we do on any background paper.

5 MR. KERR: I have a question. We have a
6 whole section in there on those who were ill that have not
7 been tabulated. In my mind, that's the most important
8 part. Will we have that included or not?

9 DR. ENTHOVEN: I think again this is one of
10 these phenomenon of trying to paint a moving train. I'm
11 concerned about discrepancies already in the existing
12 paper. I'll still be concerned. A lot of this analysis
13 just has to be carefully scrutinized and cross-checked and
14 so forth. So I was of the view we ought to deal with what
15 we have and not put in more information. Because I don't
16 know when it's going to be available, when we're going
17 have opportunities for people to review it. And we will
18 figure that the author will certainly be publishing that
19 later on. It has to be carefully scrutinized. There are
20 already numerical discrepancies in the paper that we
21 have -- that I'm troubled by.

22 MS. O'SULLIVAN: That's been out in the
23 field for two weeks now. Is there a problem? It's taken
24 so long.

25 DR. ROMERO: The time lines were just
26 delivered to us in the last 24 hours.

27 MS. SINGH: For the third part of the
28 survey.

1 DR. ROMERO: So there's been no analysis
2 done or summarization done thus far. And just speaking
3 personally, I've learned from recent experience, as Alain
4 was just alluding to, this is a very data intensive and
5 error-prone issue. And you need time to do it properly.

6 MS. O'SULLIVAN: Will the results in the
7 cross-tabs be available to task force members in the
8 future on this?

9 DR. ENTHOVEN: Sure.
10 Nancy.

11 MS. FARBER: I would recommend that the
12 Chair consider that having agreed that we're going to
13 include the report as it stands now, that the missing
14 portion of the report would be prepared in time for
15 January 5 for consideration as an inclusion with the
16 balance of the report.

17 DR. ENTHOVEN: I don't know whether it's
18 possible or not. Helen Sofler recently E-mailed me with a
19 whole list of things she has to get done in a big hurry
20 and so forth and holding off our requests for accelerating
21 some of this. All can I say is we will look into it and
22 give it our best shot. I don't control --

23 MS. FARBER: It would seem a very incomplete
24 report. Therefore, if it cannot be included because it's
25 not available, then I would like to include that what is
26 included be very clearly identified as a partial report.

27 MS. SKUBIK: Can I just say that the first
28 two phases of the survey were completed and they've been

1 analyzed and they have been tabulated and are in the
2 paper. Those two phases are the total insured population
3 of Californians and an additional super sample of another
4 1,200 Californians that have problems. That's a very
5 significant survey sample. This third sample does not
6 change the information that we have from the first two
7 samples. It's completely additional information which we
8 could conceivably write a separate summary of or
9 background paper on for perhaps the appendix. But it
10 won't change the information in the first two samples.

11 MS. FARBER: No. I think we've already
12 agreed as a task force that this isn't going in an
13 appendix; it's being included in volume 1.

14 MS. SKUBIK: I'm saying the third phase of
15 this original research was just finalized. And we've only
16 just now received the raw handwritten data.

17 MS. FARBER: And I'm telling you I don't
18 want to see that in the appendix. I want to see it in the
19 first volume with the rest of the report where it belongs,
20 not buried somewhere.

21 DR. ROMERO: Nancy, it's feasible. No
22 dispute there. It's just a question of can it be done in
23 time.

24 MS. SKUBIK: I knew that this was a very
25 ambitious project to try to do original research in this
26 amount of time. We've been able to do it for the first
27 two samples. If we're not able to get it technically
28 completed by January 5, I just can't do anything about it.

1 It's a statistical programming issue that's with U.C.
2 Berkeley and with the field research organization.

3 MS. FARBER: It shouldn't be something
4 that's buried in an appendix. When it's finished, it
5 belongs in the front volume with the other two pieces.

6 DR. ENTHOVEN: We'll do what we can. But,
7 Nancy, these things have to be carefully checked. Like do
8 these pieces add to the total. In some cases they don't
9 by large amounts. Why don't they? What got left out?
10 What are the implications and how can we account for the
11 total? There's a lot of basic statistical questions that
12 have to be scrutinized.

13 All right. We need to move forward now.
14 To get through our busy agenda as quickly and as
15 effectively as possible, members will be asked to work
16 through the lunch hour. Box lunches which were preordered
17 by staff will be delivered. Members will be asked to pay
18 for their lunch upon receipt. We'll break for lunch
19 around 12:30.

20 Also, I'd like to remind you that any
21 letters you wish to submit for inclusion in the main
22 report must be received by Alice Singh by noon on December
23 19.

24 MS. BOWNE: Excuse me, Alain. Is that to
25 you or to Alice? Can we have the precise place, please.

26 MS. SINGH: To me. FAX it to my office.
27 The FAX number is 322-4664. It's on our letterhead.

28 MS. FINBERG: What is it that has to be

1 faxed to you?

2 DR. ENTHOVEN: If you have an individual or
3 small group or group letter commenting on the findings one
4 way or another that you want included in the report, then
5 have it to Alice Singh by noon on the 19th.

6 DR. NORTHWAY: So if we send something to
7 you or to Phil, we have to sent another copy to Alice?

8 MS. SINGH: Yes. Please send it to me. I'm
9 the keeper of all paper.

10 DR. ROMERO: In your case, J.D., I'll give
11 to Alice to save you the trouble.

12 MS. SINGH: I do have yours, Dr. Northway.

13 DR. ENTHOVEN: Okay. The executive
14 director.

15 DR. ROMERO: Yes. You've covered a lot of
16 things I was going to mention. Just on the last point
17 just to clarify the discussion we just had a moment ago
18 about sending things to Alice, that refers to member
19 letters from either individual or groups of members
20 commenting on the report. Outside material we have been
21 and will continue to receive from outside sources. And
22 our e-mail address, FAX machine numbers are all over the
23 paper and back.

24 As Alain has said, we are painting a moving
25 train. And I want to draw your attention to a couple
26 papers that have been revised since they were mailed out
27 to you. What I'm about to say should not be new
28 information for anybody who's been reading recent mail.

1 But I just want to highlight it for those who haven't been
2 standing over the FAX machine for the latest FAX from
3 Phil.

4 On the public perception paper, the one we
5 were just discussing, we found some basically technical
6 fixes, in particular an illustration of a theme of a few
7 minutes ago, we found we were we misestimating the size of
8 one of the samples. And that changes many, many of the
9 figures in small ways. Those updates were made and are in
10 the public perception paper that's, I believe, in your
11 manila folder.

12 MS. SINGH: Dr. Romero, the revised public
13 perceptions paper will be distributed to you after lunch.
14 The revised regulatory organization paper is in your
15 manila folder.

16 DR. ROMERO: The changes here are very minor
17 and technical. On the regulatory organizational paper, I
18 sent you a FAX summarizing those revisions. And
19 unfortunately, I didn't bring it with me so I'll do this
20 from memory.

21 They were of two types. First, as I
22 mentioned, I tried to -- I've gotten some comments that in
23 inadvertent ways I've shown my bias in the discussion
24 about the board versus the individual director. So I
25 tried to make that discussion more balanced. In
26 particular, I reversed the order of two of the suboptions.
27 No substantive change; just reversed the order.

28 And second, I found as I gave the paper some

1 thought that I had not -- we have in the discussion about
2 the scope of jurisdiction of this new regulatory
3 organization, we're considering a number of different
4 options, some of them involving phasing its reach over
5 more and more (inaudible) in the health care system. And
6 I found that the break points I had chosen were quite as
7 reflective of the task force's discussion as I meant them
8 to be. So I changed the break points of those
9 alternatives just a bit also.

10 Let's see. That's all I have. Alice, you
11 may have a schedule or other issues.

12 MS. SINGH: An announcement. Also members,
13 the two papers that were adopted at the last meeting are
14 now made available to you and are included in your manila
15 folder. Copies were also on the back table. Those
16 findings and recommendations sections are the impact of
17 managed care on quality access and cost and the findings.
18 And the findings and recommendations for the standardizing
19 health insurance contracts.

20 The health industry profile findings were
21 also adopted at the November 21 meeting and did assume
22 some technical difficulties. That paper will be available
23 on the web on Monday and we'll send that out to task force
24 members as well.

25 DR. ROMERO: Just finally as an
26 afterthought, as you all know, we have staff both in Palo
27 Alto and in Sacramento working on different papers.
28 Sacramento has been principally responsible for the two

1 papers I mentioned a moment ago that dealt with
2 perceptions and regulatory organization.

3 If you have written comments on the public
4 perception paper, please forward them to us in Sacramento
5 because we'll be the ones implementing them.

6 MS. O'SULLIVAN: One other logistical
7 question. The transmittal statement, is that going to
8 be -- I don't know if there's going to be a menu of
9 transmittal statements or what you all are thinking about.
10 Will that be sent out to us to review ahead of time?

11 DR. ROMERO: Alain, I'm glad you're back.
12 Maryann just asked about the schedule logistics behind
13 your transmittal letter. My understanding is that you
14 intend to submit that sometime approximately December 20;
15 is that right?

16 MS. O'SULLIVAN: I'm sorry. That wasn't
17 what I meant. It wasn't about your letter, Dr. Enthoven.
18 It was about what do we say? What do we vote? Do we all
19 vote and say, "We love this"? That range.

20 MS. DECKER: Range of sensitivity.

21 DR. ENTHOVEN: There will be some
22 alternative paragraphs that people can vote on in the
23 draft of that letter is what I was thinking.

24 MS. O'SULLIVAN: Good.

25 DR. ENTHOVEN: You know, "I'm happy to
26 transmit this letter. The majority of the task force
27 agrees this reflects our findings and deliberations," or,
28 "The majority agrees it accurately reflects" or "majority

1 supports."

2 MS. O'SULLIVAN: So it's in your letter.

3 DR. ROMERO: They will see that in

4 approximately a week. Is that about right?

5 MS. SINGH: That is scheduled to go December

6 22, the menu of options.

7 DR. ENTHOVEN: Next we have to deal with the

8 October 28 meeting minutes which were in your packet.

9 That's consent item No. 4(a).

10 MS. GRIFFITHS: Mr. Chairman, I wanted to

11 note on behalf of the Assembly that the Assemblywoman

12 Thomson's name is misspelled. Her name is T-h-o-m-s-o-n.

13 There's no "P" in her name.

14 MS. SINGH: We will make that typographical

15 correction.

16 MS. GRIFFITHS: I notice Mr. Zaremborg was

17 misspelled and Ms. Belshe as well.

18 MS. SINGH: We will note those corrections.

19 This is a consent item, Mr. Chairman. Do

20 you want to ask for a motion to adopt the consent

21 calendar?

22 DR. ENTHOVEN: Is there a motion to adopt

23 the minutes? Second? All in favor? All opposed? That's

24 adopted.

25 I guess we'll take a short break. Please

26 return in five minutes. We'll just give people a bathroom

27 break opportunity. Then I'm going to work on the order in

28 which to deal with these because we have a problem of not

1 very many people here.

2 (Off the record.)

3 DR. ENTHOVEN: We have a problem that some
4 may perceive as an opportunity. That is, the last time I
5 counted, there were about 20 or possibly 21 members here.
6 And of course by our rules, we cannot pass a
7 recommendation without a vote of 16 members of the task
8 force. And if we have, for example, 21 here, then we have
9 to have a fairly super majority.

10 In some cases, that might serve as an
11 encouragement to people to look for wording that can
12 attract more votes and be less sharp edged as one way or
13 another.

14 But also with respect to the order in which
15 we take papers, I'm going to try to make just a few
16 horseback judgements as we go here, which I hope you will
17 allow me without objection, and try and identify some
18 papers that I think are less controversial and more likely
19 to win the required number of votes. And then we are
20 going to go to our procedure about voting that the
21 parliamentarian is going to explain to me. And if I can
22 understand it, then there's a good chance that everybody
23 else will understand it.

24 Alice.

25 MS. SINGH: Members, as the chairman
26 indicated, there's an opportunity for the task force not
27 to have its full compliment present. Therefore, as we
28 vote on the recommendations, if all 30 members are not

1 present and voting on a recommendation and that
2 recommendation does not secure a simple majority vote,
3 instead of indicating that that motion will fail because
4 it did not have the simple majority, any member of this
5 task force can request that we hold that vote open until
6 close of business today. If there is no objection, then
7 we will hold that vote open.

8 Therefore, in that event, what will happen
9 is I will need to call a roll call vote on that
10 recommendation so that we can ensure we do not have
11 members voting twice or what have you. So just please
12 keep in mind that this will make the process a little bit
13 longer but is necessary.

14 MR. SHAPIRO: I have a question before you
15 go to the next one. I know of a member who won't be here
16 today at all but will be here tomorrow. You said you'd
17 hold the vote open today. I also (inaudible) you can
18 reopen any issue at any time.

19 MS. SINGH: What you can do is ask for
20 reconsideration should a motion fail. That is correct.
21 And it can pass with a majority. That is correct.

22 Dr. Northway.

23 MR. NORTHWAY: What if the motion actually
24 passes with 16 or more? Does that mean that it can be
25 reopened even though there aren't 30 people here?

26 MS. SINGH: No. If the recommendation is
27 adopted by a simple majority of the task force, it's not
28 necessary to leave that open.

1 Is that clear to the members?

2 MS. BOWNE: I thought if it passed by 16,
3 it's done.

4 MS. SINGH: That's correct.

5 MS. BOWNE: It's not permissible to reopen
6 it.

7 DR. ENTHOVEN: There would be no point. I
8 see. If one of the 16 was not here tomorrow --

9 MS. SINGH: If a motion is adopted by a
10 simple majority of this task force, then that motion is
11 adopted and the business is then concluded on that
12 recommendation. This is only in the instance that we are
13 unable to secure a simple majority vote of 16.

14 Dr. Spurlock.

15 DR. SPURLOCK: Just a clarification. In
16 those instances when a majority is not obtained and the
17 request has been made to hold a vote open, open to call,
18 when will the task force members know the final
19 disposition of that discussion and when will the final
20 vote happen? Do you have to be present in person? How is
21 that going to happen when you have the final roll call?

22 MS. SINGH: What will happen, members, is
23 before we adjourn, I will read each of the recommendations
24 that still have an open call. And then I will call the
25 names of those members who have not yet voted on that
26 recommendation. At that point, this task force and the
27 public will know by what vote that recommendation passed
28 or failed.

1 Are there any other questions? Mr. Rodgers.
2 MR. RODGERS: If there is a vote that needs
3 to be deferred until tomorrow, can we vote to defer a vote
4 until tomorrow?

5 MS. SINGH: That's correct. If there is a
6 recommendation that a task force member feels it's
7 appropriate to defer the vote on that recommendation,
8 before the vote is taken, a member of this body can move
9 to defer the item until tomorrow. That motion requires a
10 second and it requires adoption, a simple majority
11 adoption, by this task force.

12 MS. FINBERG: What about after the vote is
13 taken and it still doesn't achieve the majority at the end
14 of the day? Could we say that could be held open until
15 tomorrow?

16 MS. SINGH: What you could do in that
17 instance is if I have read the roll call and it is
18 apparent or it is clear that that recommendation failed,
19 did not secure 16 votes, then any member of this body can
20 request that that recommendation be moved for
21 reconsideration tomorrow. That, again, will require a
22 second and a simple majority vote by this task force to
23 open this up for reconsideration tomorrow.

24 MR. RODGERS: A simple majority is 16?

25 MS. SINGH: 16. A simple majority of the
26 total authorized task force members is 16.

27 MS. FINBERG: Why is that different from the
28 call thing, the same day versus the next day? Is that

1 really different?

2 MS. O'SULLIVAN: Do we have to revote
3 tomorrow?

4 MS. SINGH: Yes. Because you have to
5 conclude all the business at the end of the day before the
6 meeting is adjourned. If a motion fails today, the only
7 way it can be reconsidered is by another motion for
8 reconsideration which requires a simple majority vote. So
9 16 members need to vote in favor to accept that as a
10 reconsideration item.

11 MS. FINBERG: I'm trying to save time here.
12 I wonder if we said that we're not going to adjourn until
13 tomorrow, if that would help us out.

14 MS. SINGH: I think that we need to have an
15 adjournment. Members, this is a very large body. We have
16 a lot of members present. And Mr. Lee and I actually had
17 a discussion about this. We're already bending this as it
18 is. And in order to make sure that we keep everything
19 clear, I believe this is the way that we need to do this.
20 If a recommendation doesn't pass today, then it needs to
21 be motioned for reconsideration.

22 Members, in the past if a recommendation
23 hasn't been adopted, we haven't allowed this. That's
24 basically --

25 MS. FINBERG: We're just in much more of a
26 hurry, that's all.

27 MS. SINGH: I understand. I'm trying to
28 make this as easy as possible.

1 MS. O'SULLIVAN: To help this, is there any
2 voting member who knows they are not going to be here
3 tomorrow?

4 MS. FINBERG: Depending on how late the day
5 goes.

6 MR. HAUCK: As long as we're making up rules
7 here on the fly, I don't know what the basis for some of
8 this is.

9 MS. SINGH: These are legitimate rules.

10 MR. HAUCK: Well, all right. My question is
11 if we're going to vote or if we're going to hold roll call
12 votes open, why don't we hold the roll open all day on any
13 vote and let any member who arrives vote?

14 MS. SINGH: To register?

15 MR. HAUCK: Yes. Let any member vote who
16 arrives late -- as long as the vote does not change. If
17 there's 16 votes for a recommendation and a member arrives
18 in the middle of the day or the end of the day or
19 whatever, why don't we let that person add his or her name
20 to the roll call as long as it doesn't change the outcome.

21 Wait a minute, please.

22 MS. SINGH: I'm going to agree with you.

23 MR. HAUCK: The other point I wanted to make
24 is it seems to me that we get lost to some extent in this
25 procedural process. What we're trying to achieve here as
26 much consensus as we can. Granted, we may not be able to
27 achieve a tremendous amount. But to the extent that we
28 can get more than 16 votes on recommendations, that make

1 the effect of them perhaps a little stronger when all of
2 this gets forwarded to the legislature and the governor.
3 So it seems to me that we shouldn't lose
4 ourselves in the process. We ought to provide our members
5 the opportunity to vote. And as long as a member who
6 wasn't here and arrives late doesn't change the outcome of
7 the vote or reverse the majority, I don't see any reason
8 why we shouldn't do that.

9 MS. SINGH: I can answer that, Mr. Hauck.
10 Members, you're certainly welcome to have that option.
11 What that would entail, however, that we have a roll call
12 vote on every single recommendation that's considered. I
13 don't have a problem that.

14 MR. HAUCK: That's what we were going to do,
15 isn't it?

16 MS. SINGH: What we proposed to do is only
17 have it upon request should the motion not have a simple
18 majority. If that is the will of this body to have a roll
19 call vote for every item, I don't have a problem with
20 that.

21 Are there any other questions on this?
22 Mr. Lee.

23 DR. ENTHOVEN: It's a good idea if we just
24 went into it. I mean, this is going to be endlessly
25 complex. Let's give it a try.

26 I'd like us to begin with the paper on
27 academic medical centers. And first, let me just say to
28 all of the members that I profoundly, sincerely, utterly,

1 and abjectly apologize for the fact that you did not get
2 line-in line-outs on some of these. It happened to do
3 with the computers would not produce that in time to meet
4 the deadline for computer mysteries that I don't
5 understand and can't control. So I'm awfully sorry about
6 that. I'd appreciate it if we didn't waste any more time
7 dealing with that. It was just an unfortunate thing.
8 From here forward, we will --

9 Let's see. This is tab item 6(c). So we
10 have the academic medical centers. And the question is
11 simply to adopt it. I regret that Dr. Karpf is not here.
12 And I want to say that I received a letter from
13 Mr. Gertner or Dr. Gertner of the University of
14 California, and he had a number of changes. But most of
15 those are in the background paper.

16 There was one in the front paper where he
17 wanted us to say -- if you look on page 3 in the middle of
18 the latter paragraph right in the middle it says, "USC
19 entered a voluntary agreement with the state to adjust the
20 mix." What the paper says there is, "But progress to date
21 has focused mainly on expanding priority care residency
22 programs versus making the necessary reductions in
23 specialty programs."

24 Dr. Gertner wanted to modify that to say
25 "Has achieved a 50/50 balance in residency positions."
26 And then he offers a 1997 reference. There is a problem
27 with that. One thing is last minute information that
28 hasn't been able to be verified. Another I can think of

1 is -- forgive me, Dr. Gertner, if I sound a little cynical
2 here. One neat way of correcting your
3 specialty/generalist ratio is to increase the number of
4 slots, whether they get filled or not. And so before
5 accepting his change, I would want to have some serious
6 conversation about whether that is matched by actual
7 residents on the grounds.

8 MS. BOWNE: Another is to redefine how the
9 different specialists are classified.

10 DR. ENTHOVEN: Rebecca.

11 MS. BOWNE: Another way to, shall we say,
12 read the data is to redefine how specialists are
13 classified. And I think that that would need further
14 investigation before as co whatever defender or attacker
15 of this paper I would be willing to agree to.

16 DR. ENTHOVEN: So what I'm getting from the
17 body's language is we'll go with what we got. I felt I
18 needed to call people's attention to that because that was
19 one of these late minute things.

20 Yes, Nancy.

21 MS. FARBER: Are we going to discuss these
22 papers in their contexts?

23 MS. BOWNE: We have discussed them.

24 MS. FARBER: I know we have but are we going
25 to do it again today?

26 DR. ENTHOVEN: I would entertain a motion to
27 adopt and then see if we can just march through this very
28 quickly.

1 MS. BOWNE: Motion to adopt the academic
2 medical center paper as it is.

3 MULTIPLE VOICES: Second.

4 DR. ENTHOVEN: Motion has been made and
5 seconded.

6 MS. FARBER: Can we have discussion now?

7 DR. ENTHOVEN: Yes.

8 MR. LEE: If I could just -- a procedural
9 reminder. When we have comments, can we make specific
10 page and cites and make recommendations for specific
11 changes requested.

12 DR. ENTHOVEN: We're going to do this in a
13 max of 45 minutes. And Barbara Decker has kindly agreed
14 to be our timekeeper and keep pushing us forward.

15 So Nancy Farber.

16 MS. FARBER: On page 5 of the revised
17 document, the last paragraph reads, "Health plans feel
18 themselves under pressure to pay for unproven therapies
19 which may waste money and even be harmful to patients."
20 If you're going to state that side of the
21 argument, I insist that you state the other side of the
22 argument, which is that frequently health plans contract
23 with medical centers with lesser skills and capabilities
24 based on price and deny their patients access to the
25 academic medical center where they would have very clear
26 benefit from receiving superior care.

27 MR. WILLIAMS: Is there evidence for that
28 statement?

1 DR. ENTHOVEN: In our recent investigations
2 and conversations with people at Stanford and U.C., what
3 they are saying is Stanford hospital right now is full,
4 possibly overflowing, if you'll forgive my using a local
5 anecdote. And I say, "Why?"

6 They say that apparently what has happened
7 is the less qualified hospitals who have low volume
8 programs and high cost treatments have been cutting back
9 on those to save money. And therefore, the patients have
10 been getting referred to the academic health centers. So
11 the phenomenon that seems to be the overpowering response
12 to these incentives or the dominant one is, at least for
13 Stanford and U.C., is they are getting more referrals than
14 ever.

15 MS. FARBER: I'd like to reference a 1995
16 study of pediatric heart surgery outcomes performed by
17 Kathy Jenkins, a Boston cardiologist. She studied 7,000
18 heart surgeries performed in 1992. And she found that
19 after adjusting for riskiness of surgery, patients with
20 regular commercial insurance were less likely to die than
21 those with HMO coverage. The difference was especially
22 pronounced in the largest HMO market in California.

23 And it goes on to conclude that the most
24 likely explanation for this difference were that the HMOs
25 were less willing to send their patients to preeminent
26 high cost hospitals.

27 If you're going to put one argument in, I
28 insist you put the other one in. The other option is to

1 strike that sentence.

2 DR. ENTHOVEN: Exactly what line are you on

3 on that page, Nancy?

4 MS. FARBER: I'm looking at page 5. "Health

5 plans feel themselves under pressure" --

6 DR. ENTHOVEN: In the first paragraph?

7 MS. O'SULLIVAN: Second paragraph. Can I

8 add an amendment? If we strike that sentence, we should

9 also strike the sentence that follows it. It wouldn't

10 make any sense being there by itself anyway, and it's also

11 got a lot of problems. They are not good forms for

12 evaluating efficacy but they are good forms for resolving

13 disputes.

14 DR. ENTHOVEN: Take out both sentences?

15 That's going to kind of gut an important point.

16 MS. FARBER: I would encourage you to

17 include the other argument as well.

18 DR. ENTHOVEN: My helpers are saying we're

19 having a problem. Dr. Karpf is supposed to be here this

20 afternoon. Do we know he's going to be here this

21 afternoon?

22 DR. NORTHWAY: I think we should put this

23 off then if he's going to be here. He wrote this thing.

24 DR. ENTHOVEN: Okay. I agree. Then let us

25 then take up the --

26 MR. LEE: Can we move to table?

27 DR. ENTHOVEN: Okay.

28 MR. LEE: Another process suggestion. I

1 think it's very helpful to have a specific sentence to be
2 plugged in that we can respond to. Or say, "I move this"
3 and do a quick straw poll. I think we can get quick
4 senses of language on either side to move through this.

5 MS. FINBERG: If you could also tell us what
6 the order is so we know which ones you're calling
7 noncontroversial, I think it would be helpful. I want to
8 make a phone call and I don't want to miss --

9 DR. ENTHOVEN: The next is financial
10 incentives for providers and managed care plans. Then
11 physician/patient relationships. Then when Dr. Karpf
12 arrives, we'll do academic. Then we'll do governmental
13 oversight. Or maybe then we'll try expanding consumer
14 choice and then try government oversight. The next two
15 would be financial incentives for providers and
16 physician/patient relationships.

17 DR. RODRIGUEZ-TRIAS: Could you give us tab
18 numbers?

19 MR. LEE: Physician incentives is 6(b).

20 MS. O'SULLIVAN: The agenda reflects tab
21 numbers too.

22 MS. SINGH: Yes, it does. The agenda does
23 reflect the tab numbers.

24 DR. NORTHWAY: What is the status of the
25 academic medical centers?

26 DR. ENTHOVEN: We've tabled that in the hope
27 that without objection it will be tabled until Dr. Karpf
28 arrives.

1 We're now going to discuss financial
2 incentives for providers and managed care plans. We will
3 start with -- are we going to have the same problem that
4 Donna Conom is not here? Is she on the plane?
5 MS. FARBER: I don't think Donna is planning
6 to be here today.
7 DR. ENTHOVEN: She said she was going to be
8 here? And we don't have any --
9 MS. SINGH: We don't know what her status is
10 at this point.
11 DR. ENTHOVEN: Armstead and Zaremborg said
12 they wouldn't be here today. Everyone else said they
13 would. Let's just settle it up front.
14 Is it all right to deal with this without
15 Donna?
16 MR. ZATKIN: I'm going to defend the
17 recommendations, if that's the issue. I'm going to
18 suggest some clarifying amendments. I'll go through
19 those. If you're not comfortable with doing the paper
20 unless Donna is here, that's fine.
21 DR. ENTHOVEN: Without objection, we will
22 move forward with this one. Okay. Tab 6(b). Financial
23 incentives for providers and managed care plans.
24 Steve.
25 MR. ZATKIN: Why don't we just move through.
26 Alain, do you want me to manage the votes, or do you want
27 to do that? Or do you want me to deal with my own
28 suggestions? My suggestions don't come until 4(a).

1 DR. ENTHOVEN: We will go right to the
2 recommendations. And then we'll come back.

3 MS. DECKER: Time.

4 DR. ENTHOVEN: 45 minutes.

5 MS. GRIFFITHS: Mr. Chairman, if we're going
6 to start with the recommendations, can I raise an issue
7 before the recommendations? Sorry.

8 DR. ENTHOVEN: Do we have a motion to adopt
9 the paper?

10 MS. SINGH: Members, I encourage you to not
11 make a formal motion until you've made all of your
12 technical amendments so that we can get through this
13 quickly, as I'm sure Mr. (inaudible) would appreciate
14 greatly.

15 MS. GRIFFITHS: One of my comments before
16 the recommendations is very technical. That is in
17 footnote 3 on page 1. I would suggest that we make
18 reference to the Health and Safety Code which is section
19 1367.1.

20 DR. ROMERO: The formal Health and Safety
21 Code.

22 MS. GRIFFITHS: Yes. That would be the
23 formally correct reference.

24 DR. ROMERO: Correct.

25 DR. ENTHOVEN: Okay. Thank you.

26 MS. GRIFFITHS: The other thing is in the
27 third paragraph in the text on that page, page 1, the
28 second line. The sentence starts on the first line,

1 "These relationships are often very complex and therefore
2 in most instances not amenable to regulation." I'd like
3 to suggest that we say "may not be amenable to regulation"
4 rather than be so categorical about that.

5 DR. ENTHOVEN: And therefore --

6 MS. GRIFFITHS: "May not be amenable to
7 regulation."

8 DR. ENTHOVEN: Is there any objection?
9 Okay. Fair enough.

10 Any other comments? Then we'll move right
11 to the recommendations.

12 Mr. Zatkin.

13 MR. ZATKIN: Want to just go down each one?

14 DR. ENTHOVEN: Yes.

15 MS. FINBERG: I have a suggestion on No. 1.

16 DR. ENTHOVEN: Let me say generally here the
17 way we're going to have to move if we want to get things
18 passed is to take sharp edges off of things and broaden
19 the base of support. That was coincidental that that came
20 up with you, Jeanne.

21 MS. FINBERG: Sure.

22 DR. ENTHOVEN: Whoever was the person who
23 had a comment.

24 MS. FINBERG: I don't think this is a sharp
25 edge, but you'll have to let me know. This No. 1 was
26 intended to enhance the amount of information that's
27 currently available. And I know we took a straw poll on
28 the issue of specific numbers which clearly wasn't the

1 will of the task force to disclose. I'm looking for
2 something a lot more modest that enhances on what's
3 currently available. I'm worried that just saying "scope
4 and general methods" is too vague.

5 So the language I'm suggesting is that we
6 add after the word "public" "specific information about."
7 So it reads, "Health plans should be required to disclose
8 to the public specific information about the scope and
9 general methods of payment." And then at the end of the
10 sentence it would say, "to enable consumers to evaluate
11 risks and to compare plans."

12 Did people get that? Do you want me to read
13 it again?

14 MEMBER: One more time.

15 MS. FINBERG: To the sentence that starts
16 out "how plans should be required to disclose to the
17 public" I'm going to insert "specific information about."
18 Then we'll read the rest of the sentence. "The scope and
19 general methods of payment made to their contracting
20 medical groups, IPAs, or health practitioners and the
21 types of financial incentives used." And then I'm adding
22 "to enable consumers to evaluate risks and to compare
23 plans."

24 DR. ENTHOVEN: Steve, is that friendly?
25 I'll let Steve comment.

26 MR. ZATKIN: I think that the first
27 provision is okay. I guess when you talk about evaluating
28 risks, that's kind of a negative way of putting it. Can

1 you come up with a more positive way?

2 MS. FINBERG: What would you suggest?

3 DR. ENTHOVEN: Evaluate plans?

4 MS. FINBERG: Maybe we should say "to

5 compare plans."

6 MR. ZATKIN: Fine.

7 MS. FARBER: Would you read the last

8 sentence now.

9 MS. FINBERG: It would now say, "to enable

10 consumers to evaluate and to compare plans."

11 MR. HIEPLER: I have one suggestion on that.

12 Where it says "made to the contracting medical groups,

13 IPAs, or health practitioners," one big concern is

14 capitated labs and capitated services. I think we can

15 include everything by just saying "contracting providers

16 of health care services." Because that will include

17 everything that is potentially contracted. Because a

18 patient has the right to know what the lab is being paid,

19 the two cents per month per member, whatever it is.

20 MR. ZATKIN: Mark, I think the issue there

21 is this first provision is viewed as sort of an

22 affirmative duty, which means that there has to be

23 information put into a document. The references later on

24 to providers have to do with disclosing upon request.

25 So the question is whether it's practical

26 for a plan in its documents to put down all of the kinds

27 of information that you're talking about relating to all

28 of the types of arrangements.

1 I'm going to ask Ron Williams, I'll ask Tony
2 and people who are involved in the management of plans and
3 are aware of the variation of those relationships to
4 comments on Mark's suggestion.

5 MR. WILLIAMS: It seems to me that one of
6 the challenges we're going to face in getting through this
7 is not trying to write regulations or legislation
8 ourselves, but to provide a policy direction consistent
9 with what we think is appropriate. It seems to me that's
10 a level of specificity in trying to describe the specific
11 information about the scope and general methods of
12 payment. That seems to me to be pretty clear that that's
13 the scope and general method, whether it's medical groups,
14 IPAs, and we have health practitioners which covers
15 everyone.

16 DR. ENTHOVEN: So the change is not made.

17 MR. LEE: Where there's a disagreement, I
18 suggest we just do quick straw polls on these issues to
19 see what the sense of the group is before we get things
20 passed.

21 MR. ZATKIN: My point in asking was that
22 there are lots and lots of arrangements.

23 MR. RODGERS: That's correct. I think the
24 problem is when is this information going to be used by
25 the consumer, after they are in the plan and they have
26 been assigned to an IPA that has specific arrangements
27 with certain labs? And those relationships do change.
28 And sometimes it depends on the benefit package. The

1 information would be information overload, and I don't
2 think it would add to the consumer's ability at the time
3 they're making a choice of plans to any kind of decision
4 on their part.

5 However, I think the scope and methodology,
6 as pointed out here, would be use useful information at
7 the time you're making a choice of plans and could be
8 provided in a general form. And then specifically if the
9 consumer wants to know how a specific provider is being
10 compensated, et cetera, that could be put -- and typically
11 it is.

12 MR. ZATKIN: Which goes to the point that we
13 had provision to say where the member then asks, that
14 ought to be provided. I don't know if the scope of that
15 is full.

16 MR. HIEPLER: All I was doing is simplifying
17 the words by saying "providers of health care services" to
18 include everybody. Because you might have someone in
19 there and someone gets around it by saying that's not a
20 health care practitioner. If the HMO is not contracting
21 for that and the IPA is, that's fine. Then the IPA is the
22 one that has to disclose it. It's not asking anything
23 more; it's simplifying the language.

24 DR. ENTHOVEN: I think the problem is it's
25 broadening the scope of the disclosure, and people are
26 really concerned about their doctors, to start with.
27 That's the big thing.

28 MR. HIEPLER: I'm just telling you the

1 problems you're seeing now is you get a mill that's
2 capitated and no one knows they are capitated to get a
3 second opinion. That's a real life concern that is out
4 there. I think the exact number should be disclosed, but
5 you guys have said the consumer doesn't need to know that.

6 MS. O'SULLIVAN: I want to encourage today
7 that we vote for the broader things. There are concerns
8 about all these different broad areas. We're just
9 signaling that to whoever is going to implement this. The
10 plans and everybody else is going to have lots of
11 opportunity at the legislature and the regulatory body to
12 explain which one is more important, to help prioritize.
13 We should be sending broad signals, which would go to
14 Mark's broader language for this form.

15 DR. ENTHOVEN: Let's take a straw vote on
16 Mark's language. Want to be careful --

17 MS. FARBER: Would you repeat Mark's
18 language?

19 MR. HIEPLER: Instead of "medical group,
20 IPA, or health practitioner," we just insert "providers of
21 health care services."

22 DR. ENTHOVEN: We will take a straw vote.
23 That's not going to be binding because then we'll have to
24 come back.

25 So all in favor of Mark's?
26 That's a majority of those present. That
27 change will be made then. Should we go to recommendation
28 2?

1 MS. BOWNE: Let's close out No. 1.

2 MS. SINGH: Members, you need a motion to

3 adopt recommendation No. 1 as technically amended.

4 DR. NORTHWAY: So moved.

5 MS. FARBER: Second.

6 MS. SINGH: Those in favor of adopting

7 recommendation No. 1 please raise your right hand. I need

8 to count one more time. I apologize.

9 Those opposed? The vote is 16 to 5. The

10 recommendation is adopted with a simple majority.

11 Recommendation No. 2?

12 MS. FINBERG: We had agreed to put consumer

13 groups on all of these pilot projects and tasks, and it

14 got left out.

15 MS. O'SULLIVAN: I have a comment related to

16 that, which is could we somewhere -- so we don't have to

17 say it in each recommendation, but somewhere in this

18 report up front say when we refer to consumer groups, a

19 broad range of consumer groups should be considered

20 including groups representing the disabled, seniors,

21 children, communities of color, and women? It doesn't

22 mean that every one of those groups has to be on every

23 task force. But to say that that's what we mean when we

24 say "consumer groups," then each task force can decide

25 what's the appropriate consumer group for that set of

26 work.

27 MS. BOWNE: Excuse me. I really think that

28 the notion of consumer groups is like many other things,

1 in the eyes of the beholder. And while I would certainly
2 be willing to include consumer groups, I think we need to
3 leave it at that because we're going to nitpick this to
4 death and kill each other before the end of the day.

5 MS. O'SULLIVAN: I'm only looking for a
6 broad sense.

7 DR. ENTHOVEN: Consumer understanding is the
8 broad one. You're violating the Maryann O'Sullivan rule.

9 MS. O'SULLIVAN: No. I said including, so
10 I'm not actually.

11 MR. WILLIAMS: A comment on recommendation
12 2. The beginning of the second line there, I would
13 propose to insert "of health plans and their contracting
14 medical groups." So the sentence reads, "agency for
15 regulation of managed care should conduct a pilot project
16 for a variety of health plans and their contracting
17 medical groups and other provider groups."

18 MR. LEE: And there was no objection to
19 consumer groups; is that correct?

20 DR. ENTHOVEN: Well, field tested for
21 consumer understanding and value.

22 MR. LEE: That's a totally separate issue.
23 Having a project that involves in the planning consumer
24 groups is separate than doing a survey that's administered
25 to consumers. Those are very separate issues. The field
26 testing is not at all the same concept. That's who you
27 administer a survey to, not who's involved in designing
28 something. That's not who's at the table.

1 MS. BOWNE: So am I understanding correctly,
2 then, that if we were to be inclusive we would say, "The
3 state agency for regulation of managed care should conduct
4 a pilot with a variety of health plans contracting with
5 medical groups and other provider groups, including
6 consumers, to develop" -- in other words, you want the
7 consumers in on the study so that we know that the clear
8 and simple language is understood by consumers.

9 MS. O'SULLIVAN: The language is "consumer
10 representatives," I think.

11 MS. SINGH: So "and consumer
12 representatives"?

13 DR. ENTHOVEN: The first line and a half
14 refers to the thing that is being studied, which is the
15 health plans and their medical groups and so forth. We're
16 not studying consumers.

17 MR. LEE: It seems a bizarre thing to be
18 spending so much time on. I think it's going to come up
19 again and again. This is proposing that a pilot project
20 have a number of people sitting at the table deciding
21 what's this pilot going to look like. And what some of us
22 are saying is that as part of the design of that, there
23 needs to be consumer groups at the table. I'm a little
24 confused. Seems like it should be a no-brainer.

25 MR. WILLIAMS: It's only prescriptive. I
26 think if something has to be field tested for consumer
27 understanding and value, then consumers clearly have to
28 understand it, have to be able to give value and

1 understanding. We're going to nitpick every word and be
2 here all day and all evening and not make any progress.

3 THE REPORTER: One at a time, please.

4 DR. ENTHOVEN: Thank you.

5 Diane Griffiths. First, could we see the
6 first line? "A pilot project to study a variety of health
7 plans and their contracting medical groups and other
8 provider groups." The point is they are the object of the
9 study.

10 MS. GRIFFITHS: That's one of my points. I
11 think there's been some confusion on exactly what this
12 recommendation means. Because I certainly took it the
13 way -- I forgot which one of the -- Maryann suggested put
14 in the consumer groups. I took it there was going to be a
15 bunch of medical groups and other provider groups sitting
16 around the table. And therefore, I would think --

17 DR. ENTHOVEN: No. The idea was they are
18 going to take a representative sample of health plans and
19 medical groups and work with them to develop an
20 understandable statement, and then they will field test
21 that with consumers.

22 MS. GRIFFITHS: But then they are working
23 with them. So when they develop this clear simple and
24 appropriate language, they are going to be developing it
25 with those entities. And if that's the case and health
26 plans and medical groups and other provider groups are
27 going to participate, it certainly would seem appropriate
28 to me to have consumer representatives included.

1 I have a couple other points as well.

2 DR. ENTHOVEN: Well, let's just deal with
3 that. So, Diane, did you want it to read "to study a
4 variety of health plans" and so forth to clarify that?

5 MS. GRIFFITHS: Because what I heard you
6 saying is that when you talk about developing it, yes,
7 you're going to look at a variety of health plans. But
8 the way in which the agency is going to do it is by
9 bringing them in and working with them to develop that
10 language. If they are bringing in health plans to work
11 with them to develop the language, they ought to be
12 bringing in the recipients of the care as well.

13 DR. ENTHOVEN: After "language," put in
14 "working with consumer groups"?

15 MS. FINBERG: I'm the one that made the
16 suggestion, and I feel very strongly that it needs to be
17 at the beginning up front with the provider groups. We're
18 not talking about consumers now that are field tested;
19 we're talking about policymakers. And consumer groups
20 need to be at that table. And that's the suggestion. And
21 I thought that we agreed last month that anytime we had
22 one of these task forces or pilot projects, that we are
23 going to include consumer groups. I thought it was an
24 oversight. Now it sounds like we're having a major policy
25 discussion about an issue that I consider critical.

26 DR. ENTHOVEN: What you want to do is after
27 "other provider groups" put "with consumer groups."

28 MS. FINBERG: And consumer representatives

1 or consumer groups.

2 MS. GRIFFITHS: So we would have then health
3 plans, medical groups, provider groups, and consumer
4 representatives.

5 DR. ENTHOVEN: Let's take a straw vote then.
6 How many want to add "and consumer groups"?

7 So that's in there. Any others?

8 MS. GRIFFITHS: I have two other points if
9 we're off that particular issue. One is the issue I
10 raised early on, and that is how we're going to refer to
11 the state agency. It's both a clarity question and a
12 substantive question.

13 In this particular paper, we refer to the
14 state agency in four different ways. In recommendation 2,
15 we call it "state agency for regulated managed care."
16 Then we later call it "the state agency for managed care."
17 Then we call it -- before law school, I was a professional
18 editor. Anyway, so that should be consistent.

19 But there's a substantive point linked to
20 that as well.

21 DR. ENTHOVEN: Sarah, do you have a
22 suggestion for what -- do we want to have a standard
23 term -- I think instead of having OSO and other things we
24 should just have a standard generic term.

25 MS. SINGER: What we're trying to work
26 toward is "the state agency (agencies) for regulation of
27 managed care" unless what we mean is just DOC. In which
28 case we say "the state agency."

1 MS. GRIFFITHS: I think that that's a fine
2 solution for me. But I think that somehow that should be
3 footnoted to explain what you mean by that at some point
4 in the paper. Because a layperson just picking this up --

5 MS. SINGER: So the first time it comes up,
6 we'll put "DOC" and in parenthesis "currently DOC."

7 DR. ENTHOVEN: Or "successor agency."

8 MS. GRIFFITHS: That gets to my substantive
9 question, which I'm assuming and I want to clarify. When
10 you say in recommendation No. 2 "the state agency for
11 regulation of managed care," you are not including -- and
12 I would assume that would be the case throughout this
13 paper -- not including DOI, you're simply including DOC.
14 Is that an accurate assumption?

15 DR. ENTHOVEN: The wording that way would
16 seem to be talking about "the agency," meaning DOC.

17 MS. GRIFFITHS: I'm asking if that's what's
18 intended.

19 If you look at No. 7, "The state agency for
20 regulating managed care should develop internal expertise
21 in assessing compensation arrangements." Do we mean that
22 the Department of Insurance shouldn't have that but the
23 Department of Corporations should?

24 DR. ENTHOVEN: As soon as they get to the
25 other then, fee for service, indemnity, they fall into
26 DOC, don't they? I think the intent here was -- because
27 the issue concerns capitation payments and all that sort
28 of stuff, that these are Knox-Keene plans is what we're

1 talking about. And therefore, that is the agency.

2 Would you see point 2 as being relevant to
3 DOI?

4 MS. GRIFFITHS: No, not that particular one
5 as far as just a pilot project. I might reflect on that
6 further on some of the others.

7 DR. ENTHOVEN: So can we take a real vote on
8 recommendation 2?

9 MS. SINGH: Is there a motion to adopt
10 recommendation No. 2?

11 MR. NORTHWAY: If somebody will read it.

12 MS. SINGER: Can I read it?

13 DR. ENTHOVEN: "The state agency for
14 regulated managed care should conduct a pilot project with
15 a variety of health plans and their contracting medical
16 groups and other provider groups and consumer groups."

17 MS. SINGH: Representatives.

18 DR. ENTHOVEN: "Consumer representatives to
19 develop clear, simple, and appropriate disclosure language
20 field tested for consumer understanding and value and the
21 most cost effective methods for distribution to enrollees.
22 The state agency for regulation of managed care should
23 report results back to the legislature to consider how
24 best to approach provider group disclosure."

25 MS. FINBERG: It should be "consumer
26 groups." We're not representatives. The reason is it
27 gets around the issue we were bickering about before.
28 Everybody in this room could be a consumer representative.

1 Very few of us are representatives of consumer groups.

2 DR. ENTHOVEN: So --

3 MR. WILLIAMS: I think it goes back to

4 Rebecca's point. It's in the eye of the beholder. I

5 think what we want are health consumers to try to

6 understand can a layperson understand the disclosure

7 that's being -- may I please finish?

8 And secondly, that during the development

9 process that audiences kept in mind and that we're

10 understanding, both as health plans and as provider

11 groups, that we're developing information that consumers

12 can understand.

13 DR. ENTHOVEN: I think this is good enough.

14 I think we ought to vote on what we have.

15 MS. SINGH: Do we have a motion?

16 MS. FINBERG: Do we have what I suggest in

17 my amendment?

18 DR. ENTHOVEN: Consumer groups is in there.

19 MS. FINBERG: Thank you.

20 MS. FARBER: Just as a point of

21 clarification, I think we have a problem in how we're

22 referring to the regulated agencies in the form of a

23 self-fulfilling prophecy, which was mentioned by one of

24 the commission members sitting off that way. I can't see

25 the face.

26 A simple footnote at the beginning of this

27 paper and other papers where we have a similar problem

28 saying that it's intended to reference the existing

1 agencies, DOC, DOI, where appropriate. But it also
2 anticipates that there will be action taken to create a
3 state agency that specifically has this under its
4 responsibilities.

5 MS. SINGER: Nancy, what I have done here
6 and propose to do is say "currently DOC," if that's okay.
7 We did that in other papers and I'll just do it
8 consistently.

9 DR. ENTHOVEN: She's suggesting a footnote
10 "and successor agencies" or something like that.

11 MS. SINGER: In every paper?

12 MS. FARBER: Everybody here is strongly for
13 the creation of -- it kind of underlies all the
14 assumptions we've --

15 MS. SINGER: So we'll say "DOC or successor
16 agency."

17 DR. ENTHOVEN: In the footnote the first
18 time just so we don't lengthen it.

19 Do I hear a motion to adopt?

20 MALE VOICE: So moved.

21 MR. KERR: Second.

22 DR. ENTHOVEN: All in favor of No. 2,
23 adopting No. 2?

24 MS. DECKER: While the count is going on, I
25 want to mention we have spent 24 minutes on this. We are
26 halfway through our allotted time.

27 MS. SINGH: Those opposed please raise your
28 right hand. 19 to zero. The recommendation is adopted.

1 DR. ENTHOVEN: Recommendation 3. We're
2 running overtime here.

3 MS. FARBER: I make a motion to adopt.

4 MS. SINGH: Is there a second?

5 MR. LEE: Second.

6 MS. SINGH: Discussion?

7 MR. HIEPLER: I've got one question. In
8 this context, one issue is that doctors are often
9 forbidden in their contracts from explaining the exact
10 amount they are receiving. That's been one of my big
11 points that has been defeated. According to the way this
12 is written, what are we saying, that a doctor can or
13 can't, if asked, give the specific amount?

14 DR. ENTHOVEN: I don't think we're saying or
15 taking any position on that one way or the other.

16 MR. HIEPLER: That's my concern is that
17 where does that leave a doctor if he's asked when his
18 contract with the HMO says you can't tell them the exact
19 amount? Because we're saying you shall disclose this.

20 MR. ZATKIN: Scope and method.

21 DR. ENTHOVEN: What Mark is saying is what
22 if there is a contract between a doctor and HMO?

23 MR. ZATKIN: Well --

24 DR. ENTHOVEN: It doesn't speak to that.

25 MR. ZATKIN: If it doesn't speak to the
26 amount, it speaks to the scope and method.

27 MR. HIEPLER: And that's the intent of it,
28 to leave that up in never-never land?

1 DR. ENTHOVEN: Any others? All in favor?

2 MS. SINGH: Those opposed? 21 to 1. The

3 recommendation is adopted.

4 DR. ENTHOVEN: No. 4 is sort of a redundancy

5 about including professional services.

6 Steve, would you read to us how to correct

7 it.

8 MR. ZATKIN: This unfortunately was not

9 correctly drafted. The recommended change is to strike on

10 the second line the word "the," strike the entire --

11 DR. ENTHOVEN: At the end?

12 MR. ZATKIN: At the end, yeah.

13 Strike the entire next line with the

14 exception of "A" at the end. Leave that in. And then

15 strike -- I'm sorry. That's it.

16 So it would read, "Health plans and provider

17 groups should be prohibited from adopting an incentive

18 arrangement in which an individual health practitioner

19 receives a capitation payment for a substantial portion of

20 the cost of referrals for that practitioner's patients."

21 I think that is clear and consistent.

22 DR. ENTHOVEN: Without objection, we'll

23 consider that the corrected language on the table.

24 Any discussion?

25 MS. O'SULLIVAN: I have a question.

26 MS. SINGH: You can still talk about it

27 before it's been moved.

28 DR. ENTHOVEN: Discussion? Maryann.

1 MS. O'SULLIVAN: Do we intend here by
2 "referrals" to refer to referrals for all health care
3 services that are out of the provider's office?
4 MS. SINGER: If you refer down to the
5 footnote at the bottom of the page, I think that's what we
6 tried to --
7 MS. O'SULLIVAN: It's not specialty care;
8 it's all -- okay. Good.
9 DR. SPURLOCK: I just want to make one
10 clarifier. I don't think it was the intent of the
11 language, but after discussing this particular issue with
12 several organizations, they have asked that we include the
13 words at the end "aggregated or pooled risk arrangements
14 are excluded from this prohibition." I think the intent
15 was to get to individual practitioners, not aggregated
16 amounts. So if groups of practitioners pool their risk
17 arrangement, which is common in medical groups --
18 DR. ENTHOVEN: Isn't that clearly implied by
19 saying "individual health practitioner"?
20 DR. SPURLOCK: I thought so. But there was
21 great concern about the interpretation of this.
22 DR. ENTHOVEN: Do you personally want to
23 look him in the eye and say, Bruce, "this is ambiguous"
24 when it says "individual health practitioner"?
25 DR. SPURLOCK: I don't think you and I would
26 debate this on the floor of the Senate or Assembly. I
27 don't necessarily think that's the issue. It's a simple
28 technical amendment that just clarifies that we're not

1 talking about aggregated or pooled risks.

2 MR. ZATKIN: And Alain, if it eases the

3 minds of the group to put it in and it's not inconsistent

4 with the intent, I don't see any --

5 DR. ENTHOVEN: Give us the exact language.

6 DR. SPURLOCK: Just in addition at the very

7 end of 4(a) it would say, "Aggregated or pooled risk

8 arrangements are excluded from this prohibition."

9 DR. ENTHOVEN: Pooled risk arrangements?

10 DR. SPURLOCK: That's correct. "Aggregated

11 or pooled risk arrangements are excluded from this

12 prohibition."

13 DR. NORTHWAY: Does that mean if it's two

14 people doing it, it's excluded?

15 DR. ENTHOVEN: Without objection -- Diane.

16 MS. GRIFFITHS: I guess it comes down to --

17 I don't know whether it was J.D. or who raised the issue,

18 but if it's two people -- I'm trying to understand. It's

19 not an issue we talked about in great detail about what an

20 aggregated pool risk arrangement might be. Before we make

21 it clear that we think that's okay, I'd like to hear a

22 little more about it. It does seem like it's kind of a

23 spectrum there.

24 DR. ENTHOVEN: We picked that up in (b), I

25 think.

26 MR. ZATKIN: That's correct. The idea was

27 to create a spectrum of sort of regulatory approaches by

28 focusing on the one that was most clearly problematic and

1 prohibiting that. And then kind of raising bells and
2 whistles about similar arrangements of those that involved
3 groups, small groups, in saying those need to be very
4 carefully reviewed and kind of shifting the burden, as it
5 were. So they should not be approved in the absence of
6 demonstrating that there's no --

7 MR. KERR: I wonder if we can clarify
8 because I see some confusion between this and the next
9 one. What if we said, "Aggregated or pooled risk
10 arrangements or five or more practitioners are excluded
11 from this prohibition"? That will be consistent with the
12 next one.

13 DR. SPURLOCK: That's fine. I'm not
14 trying to slip anything by you.

15 DR. ENTHOVEN: No objection to that?

16 MR. SHAPIRO: I have an objection only
17 because I was going to raise the issue in 4(b).

18 DR. ENTHOVEN: My parliamentarian says you
19 can't object.

20 MS. SINGH: You can object, you just
21 can't --

22 MR. SHAPIRO: I'm not going to vote, but I'd
23 like to object and go on record on the basis that Ron
24 Williams said policy direction is one thing; specificity
25 and micromanagement is another. What this body, I think,
26 is telling the legislature is if we take testimony that
27 five physicians comes within the gamut of very small group
28 suffering under these incentives, that we're without the

1 discretion to consider five of those as four. And I'm
2 wondering if you can consider unsharpening that number.
3 Or if there's a record that we have before us, that we can
4 add the appendices that shows this body has concluded from
5 looking at the medical profession that groups of five
6 really don't suffer under this financial constraint.

7 I just sort of leave that. In other areas
8 in parenthetical remarks, we've done "e.g.," or "for
9 example," which says that you're not necessarily taking
10 that number but it's a good guidepost you should start
11 with. And I just suggest that you give some discretion to
12 the --

13 DR. ENTHOVEN: We're giving total discretion
14 to the legislature. They are going to do what they damn
15 please, whatever we do.

16 MS. GRIFFITHS: And the governor likewise.

17 DR. ENTHOVEN: So I think, especially to the
18 legislatively oriented people, we're not writing laws.

19 MR. SHAPIRO: I'm suggesting "e.g."

20 DR. ENTHOVEN: Without objection, e.g. five
21 or more practitioners. Let's press on with 4(b) and see
22 if we can get all four in one bundle here.

23 MR. ZATKIN: A similar clarifying amendment
24 for 4(b) is second bullet, the second line, strike
25 "professional services that includes." So this would
26 read, "Where a very small group e.g. receives such an
27 incentive or a capitation payment for a substantial
28 portion of the cost of referrals for the group's

1 patients."

2 DR. ENTHOVEN: Then there's more on the next
3 page. On the top of the next page. Could we just go on
4 to (c).

5 MR. LEE: I've got to propose a wording
6 change on this where it says (b). It says, "should
7 review." As Steve noted, it's sort of shifting the burden
8 issue. I'd like this to say, "The state agency for
9 managed care" -- whatever that is -- "should be required
10 to review and approve the following arrangement." And
11 then it says the basis some shouldn't be approved. And
12 there's the standard. Otherwise, "shouldn't be approved"
13 there's no calling that these small groups are ever going
14 to be looked at. They may happen upon it somehow.

15 If we have these concerns, which I think we
16 do, we have to say that these shouldn't be happening out
17 there. And without this, it sort of says maybe that would
18 happen.

19 MR. ZATKIN: The lead in is "should review."
20 And then at the paragraph at the end it says, "These
21 arrangements should not be approved in the absence of."

22 MR. LEE: I think it's just clarifying.
23 It's saying the same thing but it's put in this front
24 rather than making it passive.

25 DR. ENTHOVEN: It is stating what I
26 understood to be the intent.

27 MR. LEE: I'm trying to clarify what it is.
28 I don't think it's anything new.

1 DR. ENTHOVEN: Any objection? Peter would
2 say go to 4(b). "The state agency for managed care" --
3 which we will of course restate -- "should be required to
4 review and approve the following types of incentive
5 arrangements."
6 MR. LEE: With the e.g. noted and the other
7 language.
8 DR. ENTHOVEN: Anything else on (b) then?
9 Can we look at (c) and then we can take a vote on the
10 package.
11 MR. ZATKIN: I have a recommendation for (c)
12 as well, which is kind of based on some of the comments we
13 heard earlier having to do with the burden of this. And
14 what I would add at the end of (c) is the following:
15 "This provision should be administered in a manner that
16 reduces the administrative burden to practitioners and
17 plans to the extent feasible." Which is an indication of
18 intent not to have a burdensome approach. "This provision
19 should be administered in a manner that reduces the
20 administrative burden on practitioners and plans to the
21 extent feasible."
22 MR. LEE: Instead of "reduces," "minimizes"?
23 MR. ZATKIN: "Minimize" is fine.
24 DR. ENTHOVEN: Want to take "minimizes"
25 then?
26 MR. ZATKIN: Yes.
27 DR. ENTHOVEN: If we minimize it, then we
28 don't have to say "to the extent feasible." "Minimizes

1 the administrative burden for plans and practitioners."

2 All right. Without objection, that will be the proposal.

3 MR. WILLIAMS: Two comments, really. One
4 would be in item (c), the very last clause, "as defined by
5 federal law." I just have a concern about linking this to
6 a lot of the processes that the federal government has
7 which come and go and change constantly. So that's really
8 one comment.

9 DR. ENTHOVEN: You would strike "as defined
10 by federal law"?

11 MR. WILLIAMS: Yes. I would strike that.

12 The other thing would be at the end of the
13 lead-in paragraph there, the sentence starts "with risk
14 cases stop/loss risk adjustment."

15 DR. ENTHOVEN: Which item?

16 MR. WILLIAMS: Strike that. I'm on (c).
17 The concept is really to indicate that they either have
18 stop/loss coverage, maintain sufficient reserves, or have
19 other verifiable mechanisms for protecting against losses.

20 DR. ENTHOVEN: All right. Say that again.

21 MR. WILLIAMS: "Through stop/loss coverage,
22 risk adjustment, or maintain sufficient reserves or have
23 other verifiable mechanisms for protecting against losses
24 due to adverse risk."

25 MR. ZATKIN: I view that, the second
26 amendment, as a friendly amendment. The first reference
27 to federal law, we have had this discussion earlier with
28 Maureen. The intention was to adopt a preexisting

1 definition of "substantial financial risk" so that we
2 wouldn't be dealing with a new definition.

3 MS. DECKER: Can you say "current federal
4 law"?

5 MR. LEE: What about "attempting to be as
6 consistent with federal law as possible"? The intent is
7 to not have multiple standards.

8 MR. ZATKIN: It was not to adopt the federal
9 procedures; it was to adopt the definition so that we
10 wouldn't have to deal with two definitions.

11 MR. WILLIAMS: My issue is the ever-changing
12 federal landscape. And if there were a benchmark that
13 said "as of this date," people know what it is.

14 MR. ZATKIN: That's fine.

15 DR. ENTHOVEN: Do you want to say "as
16 currently defined by federal law"?

17 MR. ZATKIN: Fine.

18 DR. ENTHOVEN: That's ambiguous too. Do we
19 mean currently? Then when they change it next month, we
20 have to change it?

21 MR. LEE: "Currently" seems friendly.

22 MS. SINGH: As defined --

23 DR. ENTHOVEN: "As currently defined by
24 federal law." I'm hoping now to hear a motion to adopt.

25 MR. LEE: So moved.

26 MS. SINGH: I'm sorry. Who moved?

27 MR. LEE: I did.

28 DR. ENTHOVEN: All in favor of

1 recommendation 4?

2 MS. SINGH: Those opposed? The
3 recommendation is adopted with a 20 to zero vote.

4 DR. ENTHOVEN: Next one is item 5,
5 recommendation 5.

6 MR. LEE: Any amendments being suggested, or
7 can we move this?

8 MR. WILLIAMS: My comment would be that the
9 sentence begin with "accreditation organizations such as
10 NCQA should review," then continue on.

11 DR. ENTHOVEN: Do you mean strike "sponsored
12 purchasing groups"?

13 MR. WILLIAMS: Yes. My comment is strike
14 "sponsored purchasing groups such as PBGH" and then just
15 put "accreditation." Third parties are independent. They
16 have no customer role in this process one way or another.

17 DR. ENTHOVEN: Okay. Is that friendly?
18 Everybody understand that? Any objection?

19 MR. LEE: I have an objection to that.

20 DR. ENTHOVEN: You do?

21 MR. LEE: Yeah. I really think purchasing
22 groups should be encouraging -- when we go down here, they
23 should be looking at the whole range of compensation down
24 the line. Purchasers are doing that, not just NCQA.

25 MR. SHAPIRO: I amended in this provision in
26 response to what PBGH is doing as a purchasing group on
27 this issue. I just want to remind you that they are
28 working on this issue integrating both economic and

1 non-economic factors and have a lot to bring to the table.

2 DR. ENTHOVEN: Ron.

3 MR. WILLIAMS: My issue is really with the
4 provider incentive compensation arrangements. What we're
5 essentially saying is that a health plan would sit down
6 and go through -- if I'm interpreting it correctly -- its
7 specific financial arrangements with various purchasing
8 coalitions which give range to PBGH, to California Choice,
9 or any other number of purchasing arrangements. I think
10 the rest of it seems to be appropriate roles for a
11 purchasing group being supportive of quality, best
12 practices. I think all those things are very positive.

13 MR. LEE: Maybe I misunderstood this and I
14 may be digging myself into a hole. I don't think the
15 intent was to have PBGH look at individual providers'
16 specific arrangements. I think the intent was to look at
17 how to encourage the best practices in a broader view. I
18 don't think -- and maybe the question is what does the
19 review mean.

20 MR. ZATKIN: I think that is the intent.

21 DR. ENTHOVEN: Peter?

22 MR. LEE: I'm --

23 DR. ENTHOVEN: Should review provider
24 compensation in general?

25 MR. ZATKIN: Why don't we just say "should
26 review provider incentive compensation arrangements for
27 the purpose of identifying best practices and practices in
28 need of improvement."

1 MR. LEE: Right.

2 DR. ENTHOVEN: Okay. So let me just read as

3 I understand. We've got sponsored purchasing groups such

4 as PBGH back in and accredited organizations such as NCQA

5 should review -- let me just ask. Can we leave "including

6 non-financial incentives" in there? So the only change is

7 after "compensation arrangements" on the second line, we

8 put "for the purpose of identifying." And then after the

9 parenthetical expression, we take out "to identify." All

10 right? Any objections? Okay.

11 Did I hear a motion?

12 MS. FARBER: I make a motion.

13 DR. ENTHOVEN: Thank you, Nancy. Second?

14 DR. SPURLOCK: Second.

15 DR. ENTHOVEN: All in favor?

16 MS. SINGH: Opposed? The recommendation is

17 adopted with a 20 to zero vote.

18 MS. DECKER: And we've now spent 47 minutes

19 on this paper.

20 DR. ENTHOVEN: Donna, welcome to the

21 meeting. Nice to have you here.

22 MS. CONOM: Sorry.

23 DR. ENTHOVEN: Recommendation 6.

24 MS. FARBER: Do you have any comments?

25 MR. ZATKIN: None.

26 DR. SPURLOCK: One really small -- I think

27 we discussed in previous meetings to use the concept of

28 major stakeholders rather than identify specific groups.

1 Either we use that or we add in the California Health Care
2 Association. But I think the concept of a major
3 stakeholder system is a better concept when we identify
4 these groups.

5 DR. ENTHOVEN: After "California Medical
6 Association," strike out "other industry associations."

7 MEMBERS: No, no.

8 DR. ENTHOVEN: Advisory groups should be
9 formed of major stakeholders? By the major stakeholders?
10 Then we strike "California Association of Health" --
11 strike all that?

12 MR. ZATKIN: Down to "to review."

13 DR. ENTHOVEN: That simplifies.

14 "The advisory groups should be formed by the
15 major stakeholders." Delete a bunch of stuff. Come down
16 to "to review provider compensation arrangements, identify
17 best practices and practices in need of improvement and
18 advise the state agency for regulated managed care
19 regarding the need for changes and regulatory oversight."

20 MR. RODGERS: If we say they are doing it
21 "by," they are going to do it themselves, or is it going
22 to be "of." You made a very good point. Is this "of
23 these groups by the state agency"?

24 MR. ZATKIN: It originally started as a
25 self-generating activity, and then in came to the state
26 agency last time. So that should be decided now.

27 MS. FARBER: We should clarify that now.

28 MS. O'SULLIVAN: I'd like to recommend the

1 amendment that says after the words "formed by" to insert
2 "the state agency that monitored," blah, blah, blah "and
3 including." And it should include whatever state --
4 MR. LEE: Or "convened by" the state agency
5 group.
6 DR. ENTHOVEN: I'll tell you. This comes up
7 later on with the technology assessment issue where
8 antitrust is a very important issue. And if lawyers will
9 bear with me. Where's Mark?
10 In entities like this, you risk antitrust
11 suits. But if it's convened by the state, then this comes
12 in under the state action exclusion.
13 MS. GRIFFITHS: You're on the money there.
14 DR. ENTHOVEN: "Convened by the regulatory
15 agency," blah, blah, blah.
16 MS. O'SULLIVAN: Another thing. If we're
17 going to say "stakeholders," could we say somewhere
18 "including consumer groups"? It could be a footnote. It
19 could be something.
20 MR. HAUCK: They are major stakeholders.
21 MS. O'SULLIVAN: Let's say what we mean by
22 "stakeholders." I don't know. I worry.
23 DR. ENTHOVEN: Come on. We'll have a
24 footnote about stakeholders.
25 MS. O'SULLIVAN: Thank you.
26 DR. ROMERO: A global one.
27 DR. ENTHOVEN: "Advisory groups should be
28 convened by the regulatory agency, including the major

1 stakeholders, to review provider compensation
2 arrangements."

3 MR. LEE: Any other amendments before I move
4 adoption? Move adoption.

5 MS. BOWNE: Second.

6 DR. ENTHOVEN: All in favor, please raise
7 your hand.

8 MS. SINGH: Those opposed? The
9 recommendation is adopted by a vote of 24 to zero.

10 DR. ENTHOVEN: No. 7.

11 MR. LEE: No amendments.

12 DR. ENTHOVEN: Did I hear you make a motion?

13 MR. LEE: Move adoption.

14 DR. ENTHOVEN: All in favor? I thought that
15 was going to be a close one.

16 MR. LEE: Can we hold this over?

17 MS. SINGH: Those opposed? 23 votes in
18 support. The recommendation is adopted 23 to zero.

19 MS. DECKER: Mr. Chair, I have one general
20 comment on this. I understood our protocol that we needed
21 to have an introductory comment for recommendations that
22 say "we recommend the governor and legislature" type
23 wording, and this doesn't have it in it. Is this an
24 issue? Are we asking the governor and the legislature to
25 do these things?

26 DR. SPURLOCK: Can I respond to that?

27 DR. ENTHOVEN: Go ahead. Bruce.

28 DR. SPURLOCK: I thought in one of our

1 earlier discussions we talked about the fast-moving nature
2 and complexity doesn't lend itself better to the
3 regulatory environment (inaudible) that's why we choose a
4 state agency for oversight because it's so fast moving and
5 so complex. So I think the appropriate direction is to
6 the state agency rather than the governor or the
7 legislature.

8 DR. ENTHOVEN: The governor is free to read
9 that and tell them to do it. And the legislature is free
10 to read that and tell him to do something different.

11 MS. GRIFFITHS: Mr. Chairman, I think with
12 regard to some of those definitions, (inaudible). I would
13 suggest that another potential way to deal with this --
14 let me back up one second. One of the issues is that from
15 section to section, there's an inconsistency in this
16 regard. That is, in some sections we say the legislature
17 and the governor "should do." We require them to do this
18 and that. In others, we simply say they should be
19 required to do it. I think it might be better to simply
20 say that they should be required to do it and then some
21 general footnote indicating that where appropriate, that
22 may take legislative action.

23 MR. LEE: Or regulatory action or whatever.
24 The nature of how this would be required.

25 MS. GRIFFITHS: If we go through these one
26 by one, it will take a long, long time.

27 DR. ENTHOVEN: So Diane, take No. 6. How
28 would you word that? For example, as a prototype, how

1 would you do No. 6? Then would you say, "The governor and
2 the legislature should require"?

3 MS. GRIFFITHS: What I'm suggesting is that
4 in those cases where you want the plan to be required to
5 do something or the provider or whomever, you simply say
6 "the plan should be required," et cetera. And then
7 somewhere in the introduction of this you have an
8 explanation that where requirements are imposed on various
9 entities, there may be legislative or regulatory action
10 taken. Or in some cases, the agencies may already have
11 the authority to take that action independent of
12 legislation.

13 MS. DECKER: Are you suggesting just for
14 this paper?

15 DR. ROMERO: To clarify, Diane, I assume
16 that would mean all references to governor and legislature
17 we would delete to be superseded by this clarification.

18 MS. GRIFFITHS: Except in a few cases where
19 we're asking for reports to them. We need to keep that.

20 DR. ENTHOVEN: Would you kindly agree to be
21 available by telephone to Sarah next week?

22 MS. GRIFFITHS: She has my phone number.
23 She hasn't used it yet.

24 DR. ENTHOVEN: That is that you will work
25 together to create kind of a generic statement to that.
26 Maryann.

27 MS. O'SULLIVAN: I was going to say that so
28 we don't have to raise this as we go along. We can count

1 on that throughout all these papers?

2 DR. ENTHOVEN: To the best of our limited

3 abilities.

4 MS. O'SULLIVAN: Yes.

5 MR. LEE: I'd like to move adoption of the

6 findings section, which is the other thing we do after

7 going through recommendations.

8 MS. SINGH: Findings and recommendations are

9 taken as a whole.

10 DR. ENTHOVEN: All in favor?

11 MS. SINGH: 22. Those opposed? 22 to zero.

12 DR. ENTHOVEN: Lunch is ready. We're going

13 to go off-line for about 20 minutes while the court

14 reporter changes the tapes while we get our lunch. So I

15 hope we back here on deck by 12:50.

16 (Lunch recess.)

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1 STATE OF CALIFORNIA)
) ss.
2 COUNTY OF LOS ANGELES)

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4 I, Joanna Austin, CSR 10380, a certified
5 Shorthand Reporter in and for the State of California, do
6 hereby certify:

7 That the foregoing proceeding was taken down
8 by me in shorthand at the time and place named therein and
9 was thereafter reduced to typewriting under my
10 supervision; that this transcript is a true, full and
11 correct record of the proceedings which took place at the
12 time and place set forth in the caption hereto as shown by
13 my original stenographic notes.

14 I further certify that I have no interest in
15 the event of the action.

16

17 EXECUTED this 16th day of December , 1997.

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20 Joanna Austin, CSR #10380

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